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TITLES I-XX
OF THE
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1987-1988
Part 2



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Volume XXIII
100th Congress
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Part 2

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100TH CONGRESS
1st Session

HOUSE OF REPRESENTATIVES

REPORT
100-495

OMNIBUS BUDGET RECONCILIATION ACT OF 1987

CONFERENCE REPORT

TO ACCOMPANY

H.R. 3545



DECEMBER 21, 1987.—Ordered to be printed

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100TH CONGRESS
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REPORT
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OMNIBUS BUDGET RECONCILIATION ACT OF 1987

DECEMBER 21, 1987.—Ordered to be printed

Mr. GRAY of Pennsylvania, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany H.R. 3545]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3545) to provide for reconciliation pursuant to section 4 of the concurrent resolution on the budget for the fiscal year 1988, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Omnibus Budget Reconciliation Act of 1987".

SEC. 2. TABLE OF CONTENTS.

Title I—Agriculture and related programs.
Title II—National Economic Commission.
Title III—Education programs.
Title IV—Medicare, medicaid, and other health-related programs.
Title V—Energy and environmental programs.
Title VI—Civil service and postal service programs.
Title VII—Veterans' programs.
Title VIII—Budget policy and fiscal procedures.
Title IX—Income security and related programs.
Title X—Revenues.

TITLE IV—MEDICARE, MEDICAID, AND OTHER HEALTH-RELATED PROGRAMS

TABLE OF CONTENTS

TITLE IV—MEDICARE, MEDICAID, AND OTHER HEALTH-RELATED PROGRAMS

Subtitle A—Medicare

PART 1—RELATING ONLY TO PART A

Sec. 4001. Extension of reductions under sequester order.
Sec. 4002. Basic hospital prospective payment rates.
Sec. 4003. Increase in disproportionate share adjustment and reduction in indirect medical education payments.
Sec. 4004. Provisions relating to wage index.
Sec. 4005. Rural hospitals.
Sec. 4006. Payments for hospital capital.
Sec. 4007. Reporting hospital information.
Sec. 4008. Other provisions relating to payment for inpatient hospital services.
Sec. 4009. Miscellaneous provisions.

PART 2—PROVISIONS RELATING TO PARTS A & B

SUBPART A—HEALTH MAINTENANCE ORGANIZATION REFORMS

Sec. 4011. Beneficiary protection.
Sec. 4012. Payments for hospital services.
Sec. 4013. Two-year extension on period for benefit stabilization.
Sec. 4014. Civil money penalties and intermediate sanctions against HMOs/CMPs.
Sec. 4015. Medicare payment demonstration projects.
Sec. 4016. Delay in effective date in physician incentive rules for health maintenance organizations.
Sec. 4017. GAO study and reports on medicare capitation.
Sec. 4018. Special rules.

SUBPART B—HOME HEALTH QUALITY

Sec. 4021. Conditions of participation for home health agencies.
Sec. 4022. Standard and extended survey.
Sec. 4023. Enforcement.
Sec. 4024. Requirement that individual be confined to home.
Sec. 4025. Home health toll-free hotline and investigative unit.
Sec. 4026. Home health agency cost limits.
Sec. 4027. Home health prospective payment demonstration project.

SUBPART C—OTHER PROVISIONS

Sec. 4031. Payment cycle standards.
Sec. 4032. Denials and reconsiderations of claims for home health services, extended care services, and post-hospital extended care services.
Sec. 4033. Permitting disabled individuals to renew entitlement to medicare after gainful employment without a 2-year waiting period.
Sec. 4034. Application of secondary payer provisions to governmental entities.
Sec. 4035. Publication and notification of policies.
Sec. 4036. End-stage renal disease amendments.
Sec. 4037. Medicare hearings and appeals.
Sec. 4038. Rural health medical education demonstration project.
Sec. 4039. Miscellaneous and technical provisions.

PART 3—RELATING TO PART B

SUBPART A—PROVISIONS RELATING TO PAYMENTS FOR PHYSICIANS' SERVICES

Sec. 4041. Freeze in payments for physicians' services; extension of sequester order.
Sec. 4042. General update in payments for physicians' services.
Sec. 4043. Incentive payments for physicians' services furnished in underserved areas.
Sec. 4044. Adjustment in prevailing charge level for primary care services.

Sec. 4045. Reduction in prevailing charge level for overpriced procedures.
Sec. 4046. Limits on payment for ophthalmic ultrasound.
Sec. 4047. Customary charges for primary care services of new physicians.
Sec. 4048. Payment for physician anesthesia services.
Sec. 4049. Fee schedules for radiologist services.
Sec. 4050. Fee schedules for physician pathology services.
Sec. 4051. Elimination of markup for certain purchased services.
Sec. 4052. Collection of past-due amounts owed by physicians who breached contracts under the National Health Service Corps Scholarship Program.
Sec. 4053. Application of maximum allowable actual charge (MAAC).
Sec. 4054. Applying copayment and deductible to certain outpatient physicians' services.
Sec. 4055. Physician payment studies.

SUBPART B—PROVISIONS RELATING TO PAYMENTS FOR OTHER SERVICES

Sec. 4061. Extension of reduction for other part B items and services payments under sequester order.
Sec. 4062. Payments for durable medical equipment, prosthetic devices, orthotics, and prosthetics.
Sec. 4063. Payment for intraocular lenses.
Sec. 4064. Clinical diagnostic laboratory tests.
Sec. 4065. Return on equity payments to outpatient departments.
Sec. 4066. Payments to hospital outpatient departments for radiology.
Sec. 4067. Updating maximum rate of payment per visit for independent rural health clinics.
Sec. 4068. Payment for ambulatory surgery at eye, and eye and ear, specialty hospitals.

SUBPART C—ELIGIBILITY AND BENEFITS CHANGES

Sec. 4070. Coverage of mental health services.
Sec. 4071. Coverage of influenza vaccine and its administration.
Sec. 4072. Payment for therapeutic shoes for individuals with severe diabetic foot disease.
Sec. 4073. Coverage of certified nurse-midwife services.
Sec. 4074. Coverage of social worker services furnished by a health maintenance organization to its members.
Sec. 4075. Clarification of coverage of drugs used in immunosuppressive therapy.
Sec. 4076. Services of a physician assistant.
Sec. 4077. Psychologist services in clinics.
Sec. 4078. Provision of offsite comprehensive outpatient rehabilitation services.
Sec. 4079. Demonstration projects to provide payment on a prepaid, capitated basis for community nursing and ambulatory care furnished to medicare beneficiaries.
Sec. 4080. Part B premium.

SUBPART D—OTHER PROVISIONS

Sec. 4081. Submission of claims to supplemental insurance carriers.
Sec. 4082. Revision of part B hearings.
Sec. 4083. Provisions relating to Physician Payment Review Commission.
Sec. 4084. Technical amendments related to certified registered nurse anesthetists.
Sec. 4085. Miscellaneous and technical provisions.

PART 4—PEER REVIEW ORGANIZATIONS

Sec. 4091. Contract provisions.
Sec. 4092. Preference in contracting with in-State organizations.
Sec. 4093. Requiring reasonable notice and opportunity for discussion prior to denial of claim.
Sec. 4094. Reer review norms and education.
Sec. 4095. Preexclusion hearings.
Sec. 4096. Limitation of beneficiary liability for services disallowed by peer review organizations.
Sec. 4097. Separate funding levels.

Subtitle B—Medicaid

Part 1—Eligibility and Benefits

Sec. 4101. Medicaid benefits for poor children and pregnant women.
Sec. 4102. Home and community-based services for the elderly.
Sec. 4103. Physicians' services furnished by dentists.
Sec. 4104. Optional medicaid coverage of individuals in certain states receiving only optional state supplementary payments.
Sec. 4105. Miscellaneous SSI-related amendments.
Sec. 4106. Clarification of coverage of clinic services furnished to homeless outside facility.
Sec. 4107. Medically needy income levels for certain 2-member couples in California.

Part 2—Other Provisions

Sec. 4111. Increasing the maximum annual medicaid payments that may be made to the commonwealths and territories.
Sec. 4112. Adjustment in medicaid payment for inpatient hospital services furnished by disproportionate share hospitals.
Sec. 4113. HMO-related provisions.
Sec. 4114. Medicaid waiver for hospice care for AIDS patients.
Sec. 4115. State demonstration projects.
Sec. 4116. Waiver authority under the medicaid program for the Northern Mariana Islands.
Sec. 4117. Delay quality control sanctions for Medicaid.
Sec. 4118. Technical and miscellaneous amendments.

Subtitle C—Nursing Home Reform

Part 1—Medicare Program

Sec. 4201. Requirements for skilled nursing facilities.
Sec. 4202. Survey and certification process.
Sec. 4203. Enforcement process.
Sec. 4204. Effective dates.
Sec. 4205. Annual report.
Sec. 4206. Construction.

Part 2—Medicaid Program

Sec. 4211. Requirements for nursing facilities.
Sec. 4212. Survey and certification process.
Sec. 4213. Enforcement process.
Sec. 4214. Effective dates.
Sec. 4215. Annual report.
Sec. 4216. Construction.
Sec. 4217. Final regulations with respect to plans of correction or reduction.
Sec. 4218. Medicaid certifications and recertifications for certain services.

Subtitle D—Vaccine Compensation

Sec. 4301. Short title, reference.
Sec. 4302. Effective date.
Sec. 4303. Compensation.
Sec. 4304. Petitions.
Sec. 4305. Citizen's actions.
Sec. 4306. Vaccine administrators.
Sec. 4307. Court jurisdiction.

Subtitle E—Rural Health

Sec. 4401. Office of Rural Health Policy.
Sec. 4402. Impact analyses of medicare rules and regulations on small rural hospitals.
Sec. 4403. Set aside for experiments and demonstration projects relating to rural health care issues.

PART 1—RELATING ONLY TO PART A

SEC. 4001. EXTENSION OF REDUCTIONS UNDER SEQUESTER ORDER.

Notwithstanding any other provision of law (including any other provision of this Act), the reductions in the amount of payments required under title XVIII of the Social Security Act made by the final sequester order issued by the President on November 20, 1987, pursuant to section 252(b) of the Balanced Budget Emergency Deficit Control Act of 1985 shall continue to be effective (as provided by sections 252(a)(4)(B) and 256(d)(2) of such Act) through—

(1) March 31, 1988, with respect to payments for inpatient hospital services under such title (including payments under section 1886 of such title attributable or allocated to part A of such title); and

(2) December 31, 1987, with respect to payments for other items and services under part A of such title.

SEC. 4002. BASIC HOSPITAL PROSPECTIVE PAYMENT RATES.

(a) BASIC UPDATE FACTOR FOR PPS HOSPITALS.—Clause (i) of section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)) is amended by striking "and for fiscal year 1988" in subclause (II) and all that follows through the end of such clause and inserting after such subclause the following:

"(III) for fiscal year 1988, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for other hospitals,

"(IV) for fiscal year 1989, the market basket percentage increase minus 1.5 percent for hospitals located in a rural area, the market basket percentage increase minus 2.0 percent for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percent for other hospitals, and

"(V) for fiscal year 1990 and each subsequent fiscal year, the market basket percentage for hospitals in all areas.".

(b) LARGE URBAN AREA DEFINED.—The second sentence of section 1886(d)(2)(D) of such Act (42 U.S.C. 1395www(d)(2)(D)) is amended by inserting after "under subsection (a) by regulation;" the following: "the term 'large urban area' means, with respect to a fiscal year, such an urban area which the Secretary determines (in the publication described in subsection (e)(5)(B) before the fiscal year) has a population of more than 1,000,000 (as determined by the Secretary based on the most recent available population data published by the Bureau of the Census);".

(c) ADJUSTMENT FOR HOSPITALS IN LARGE URBAN AREAS OR IN RURAL AREAS.—

(1) IN GENERAL.—Section 1886(d)(3) of such Act (42 U.S.C. 1395ww(d)(3)) is amended—

(A) in the matter before subparagraph (A), by striking "urban or rural areas" and inserting "large urban, other urban, or rural areas";

(B) in first sentence of subparagraph (A)—

(i) by striking "The Secretary" and inserting "(i) For discharges occuring in a fiscal year beginning before October 1, 1987, the Secretary",

(ii) by striking "each of fiscal years 1985, 1986, 1987, and 1988" and inserting "the fiscal year involved", and

(iii) by striking ", and adjusted for subsequent fiscal years in accordance with the final determination of the Secretary under subsection (e)(4), and adjusted to reflect the most recent case-mix data available,";

(C) by adding at the end of subparagraph (A) the following new clauses:

"(ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

"(iii) Average standardized amounts computed under this paragraph shall be adjusted to reflect the most recent case-mix data available."; and

(D) in subparagraph (D)—

(i) by striking "URBAN AND RURAL HOSPITALS" in the heading and inserting "HOSPITALS IN DIFFERENT AREAS",

(ii) in clause (i), by inserting "(or, for discharges occurring on or after April 1, 1988, in a large urban area or other urban area)" after "urban area" the first place it appears, and

(iii) in clause (i), by inserting "such" before "an urban area" the second place it appears.

(2) CONFORMING AMENDMENTS.—Section 1886(d)(9)(A) of such Act (42 U.S.C. 1395ww(d)(9)(A)) is amended—

(A) in clause (ii)(I), by striking "an urban area, and" and inserting "a large urban area,";

(B) by redesignating subclause (II) of clause (ii) as subclause (III); and

(C) by inserting after subclause (I) of clause (ii) the following new subclause:

"(II) such rate for hospitals located in other urban areas, and".

(d) ESTABLISHMENT OF REGIONAL FLOOR.—Section 1886(d)(1)(A)(iii) of such Act (42 U.S.C. 1395ww(d)(1)(A)(iii)) is amended by inserting before the period at the end the following: ", or, if greater for discharges occurring during the period beginning on April 1, 1988, and ending on September 30, 1990, the sum of (I) 85 percent of the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges, and (II) 15 percent of the regional adjusted DRG prospective payment rate determined under such paragraph".

(e) UPDATE FOR PPS-EXEMPT HOSPITALS.—Section 1886(b)(3)(B) of such Act (42 U.S.C. 1395ww(b)(3)(B)) is amended—

(1) in clause (i), by striking "subparagraph (A) for 12-month cost reporting periods beginning during a fiscal year and for purposes of",

(2) in clause (ii), by striking "(ii) For purposes of clause (i)" and inserting "(iii) For purposes of this subparagraph", and

(3) by inserting after clause (i) the following new clause:

"(ii) For purposes of subparagraph (A), the 'applicable percentage increase' for 12-month cost reporting periods beginning during—

"(I) fiscal year 1986, is 0.5 percent,

"(II) fiscal year 1987, is 1.15 percent,

"(III) fiscal year 1988, is the market basket percentage increase minus 2.0 percentage points, and

"(IV) subsequent fiscal years is the market basket percentage increase.".

(f) RELATED CONFORMING AND TECHNICAL AMENDMENTS.—

(1) Section 1886 of such Act (42 U.S.C. 1395ww) is further amended—

(A) by adding at the end of subsection (d)(2)(D) the following new sentence: "For purposes of payment under this subsection, a hospital is considered to be located in an urban area or large urban area, respectively, if the hospital is paid under this subsection at the rate for hospitals located in such an area.";

(B) in subsection (e)(3)(B), by striking "or determine";

(C) in subsection (e)(4)—

(i) by striking "for fiscal year 1988" and inserting "for each fiscal year (beginning with fiscal year 1988)",

(ii) by striking "and shall determine for each subsequent fiscal year" and all that follows through "fiscal year, and", and

(iii) by amending the last sentence to read as follows: "The appropriate change factor may be different for all large urban subsection (d) hospitals, other urban subsection (d) hospitals, urban subsection (d) Puerto Rico hospitals, rural subsection (d) hospitals, and rural subsection (d) Puerto Rico hospitals, and all other hospitals and units not paid under subsection (d), and may vary among such other hospitals and units."; and

(D) in paragraph (5), by striking "or determination" each place it appears.

(2) Subsection (a)(1)(B)(ii) of section 107 of the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987 (Public Law 100-119) is amended, effective as of the date of the enactment of such Act, by inserting ", the target percentage and DRG percentage shall be those specified in subsection (d)(1)(C)(iv) of such section, and the applicable percentage increase in a hospital's target amount shall be deemed to be 0 percent" before the period at the end.

(g) EFFECTIVE DATES.—

(1) PPS HOSPITALS, DRG PORTION OF PAYMENT.—In the case of a subsection (d) hospital (as defined in paragraph (6))—

(A) the amendments made by subsections (a) and (c) shall apply to payments made under section 1886(a)(1)(A)(iii) of

the Social Security Act on the basis of discharges occurring on or after April 1, 1988, and

(B) for discharges occurring on or after October 1, 1988, the applicable percentage increase (described in section 1886(d)(3)(B) of such Act)) for discharges occurring during fiscal year 1987 is deemed to have been such percentage increase as amended by subsection (a).

(2) PPS SOLE COMMUNITY HOSPITALS, HOSPITAL SPECIFIC PORTION OF PAYMENT.—In the case of a subsection (d) hospital which receives payments made under section 1886(d)(1)(A) of the Social Security Act because it is a sole community hospital—

(A) the amendment made by subsections (a) and (c) shall apply to payments under section 1886(d)(1)(A)(ii)(I) of the Social Security Act made on the basis of discharges occurring during a cost reporting period of a hospital, for the hospital's cost reporting period beginning on or after October 1, 1987;

(B) notwithstanding subparagraph (A), for cost reporting period beginning during fiscal year 1988, the applicable percentage increase (as defined in section 1886(d)(3)(B) of such Act) for the—

(i) first 51 days of the cost reporting period shall be 0 percent,

(ii) next 132 days of such period shall be 2.7 percent, and

(iii) remainder of such period of the cost reporting period shall be the applicable percentage increase (as so defined, as amended by subsection (a)); and

(C) for cost reporting periods beginning on or after October 1, 1988, the applicable percentage increase (as so defined) with respect to the previous cost reporting period shall be deemed to have been the applicable percentage increase (as so defined, as amended by subsection (a)).

(3) PPS-EXEMPT HOSPITALS.—In the case of a hospital that is not a subsection (d) hospital—

(A) the amendments made by subsection (e) shall apply to cost reporting periods beginning on or after October 1, 1987;

(B) notwithstanding subparagraph (A), for the hospital's cost reporting period beginning during fiscal year 1988, payment under title XVIII of the Social Security Act shall be made as though the applicable percentage increase described in section 1886(b)(3)(B) of such Act were equal to the product of 2.7 percent and the ratio of 315 to 366; and

(C) for cost reporting periods beginning on or after October 1, 1988, the applicable percentage increase (as so defined) with respect to the cost reporting period beginning during fiscal year 1988 shall be deemed to have been 2.7 percent.

(4) DEFINITION, REGIONAL FLOOR, AND TECHNICAL AND CONFORMING AMENDMENTS.—The amendments made by subsections (b) and (d) and paragraphs (1) and (2) of subsection (f) shall take effect on the date of the enactment of this Act.

(5) TRANSITION FOR LARGE URBAN AREA RATES.—In computing the average standardized amount for hospitals located in a

large urban area or other urban area under section 1886(d)(3)(A)(ii) of the Social Security Act (as amended by subsection (c)) for fiscal year 1988, the reference to "the respective average standardized amount computed for the previous fiscal year under this subparagraph" is deemed a reference to the average standardized amount computed for hospitals located in an urban area for the 51-day period beginning on October 1, 1987.

(6) DEFINITION.—In this subsection, the term "subsection (d) hospital" has the meaning given such term in section 1886(d)(10)(B) of the Social Security Act.

SEC. 4003. INCREASE IN DISPROPORTIONATE SHARE ADJUSTMENT AND REDUCTION IN INDIRECT MEDICAL EDUCATION PAYMENTS.

(a) REDUCTION IN INDIRECT MEDICAL EDUCATION PAYMENTS.—

(1) Section 1886(d)(5)(B)(ii) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(A) in subclause (I), by striking "2" and inserting in lieu thereof "1.89"; and

(B) in subclause (II), by striking "1.5" and inserting in lieu thereof "1.43".

(2) Section 1886(d)(3)(C)(ii) of such Act (42 U.S.C. 1395ww(d)(3)(C)(ii)) is amended by inserting "and by section 4003(a)(1) of the Omnibus Budget Reconciliation Act of 1987" after "1985" each place it appears in subclauses (I) and (II).

(b) INCREASE IN DISPROPORTIONATE SHARE ADJUSTMENT.—Section 1886(d)(5)(F) of such Act (42 U.S.C. 1395ww(d)(5)(B))—

(1) in clause (iii), by striking "15 percent" and inserting "25 percent", and

(2) in clause (iv)(I), by striking "the lesser of 15 percent, or".

(c) EXTENSION OF DISPROPORTIONATE SHARE ADJUSTMENT.—Sections 1886(d)(2)(C)(iv) (42 U.S.C. 1395ww(d)(2)(C)(iv)), 1886(d)(3)(C)(ii)(I) (42 U.S.C. 1395ww(d)(3)(C)(ii)(I)), 1886(d)(3)(C)(ii)(II) (42 U.S.C. 1395ww(d)(3)(C)(ii)(II)), 1886(d)(5)(B)(ii)(I) (42 U.S.C. 1395ww(d)(5)(B)(ii)(I)), 1886(d)(5)(B)(ii)(II) (42 U.S.C. 1395ww(d)(5)(B)(ii)(II)), and 1886(d)(5)(F)(i) (42 U.S.C. 1395ww(d)(5)(F)(i)) of the Social Security Act are each amended by striking "1989" and inserting in lieu thereof "1990".

(d) SPECIAL RULE.—In the case of a hospital which—

(1) consists of 2 inpatient hospital facilities which are more than 4 miles apart and each of which is in a separate political jurisdiction within the same State and one of which meets the criteria under section 1886(d)(5)(F) of the Social Security Act for serving a significantly disproportionate number of low-income patients as if that facility were a separate hospital; and

(2) receives payments for inpatient hospital services under title XVIII of the Social Security Act which are less than the hospital's reasonable costs,

the Secretary of Health and Human Services, upon application by the hospital, may treat each of the facilities of hospital as separate hospitals for purposes of applying section 1886(d)(5)(F) of the Social Security Act, for discharges occurring on or after October 1, 1988.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to payments for discharges occurring on or after October 1, 1988.

SEC. 4004. PROVISIONS RELATING TO WAGE INDEX.

(a) SURVEY.—Section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) is amended by adding at the end the following: "Not later than October 1, 1990 (and at least every 36 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of a survey conducted by the Secretary (and updated as appropriate) of the wages and wage-related costs of subsection (d) hospitals in the United States. To the extent determined feasible by the Secretary, such survey shall measure the earnings and paid hours of employment by occupational category and shall exclude data with respect to the wages and wage-related costs incurred in furnishing skilled nursing facility services.".

(b) CLINIC HOSPITAL WAGE INDICES.—In calculating the wage index under section 1886(d) of the Social Security Act for purposes of making payment adjustments after September 30, 1988, as required under paragraphs (2)(H) and (3)(E) of such section, in the case of any institution which received the waiver specified in section 602(k) of the Social Security Amendments of 1983, the Secretary of Health and Human Services shall include wage costs paid to related organization employees directly involved in the delivery and administration of care provided by the related organization to hospital inpatients. For purposes of the preceding sentence, the term "wage costs" does not include costs of overhead or home office administrative salaries or any costs that are not incurred in the hospital's Metropolitan Statistical Area.

SEC. 4005. RURAL HOSPITALS.

(a) REVISION OF STANDARDS FOR INCLUDING A RURAL COUNTY IN AN URBAN AREA.—

(1) TREATING CERTAIN RURAL HOSPITALS ADJACENT TO URBAN AREAS AS URBAN HOSPITALS.—Section 1886(d)(8) of the Social Security Act (42 U.S.C. 1395ww(d)(8))—

(A) by redesignating clauses (i) and (ii) of subparagraphs (A) and (B) as subclauses (I) and (II), respectively,

(B) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively,

(C) by inserting "(A)" after "(8)", and

(D) by adding at the end the following new subparagraph:

"(B) The Secretary shall treat a hospital located in a rural county adjacent to one or more urban areas as being located in the urban metropolitan statistical area to which the greatest number of workers in the county commute, if—

"(i) the rural county would otherwise be considered part of an urban area but for the fact that the rural county does not meet the standard relating to the rate of commutation between the rural county and the central county or counties of any adjacent urban area; and

"(ii) either (I) the number of residents of the rural county who commute for employment to the central county or counties of any adjacent urban area is equal to at least 15 percent of the

number of residents of the rural county who are employed, or (II) the sum of the number of residents of the rural county who commute for employment to the central county or counties of any adjacent urban area and the number of residents of any adjacent urban area who commute for employment to the rural county is at least equal to 20 percent of the number of residents of the rural county who are employed.

"(C) The Secretary shall make a proportional adjustment in the standardized amount determined under paragraph (3) for hospitals located in an urban area to assure that the provisions of subparagraph (B) do not result in aggregate payments under this section that are greater or less than those that would otherwise be made. The Secretary shall make such adjustment in payments under this section to hospitals located in rural areas as are necessary to assure that the aggregate of payments to rural hospitals not affected by subparagraph (B) are not changed as a result of the application of subparagraph (B).".

(2) LOCATION OF HOSPITAL.—For purposes of section 1886 of the Social Security Act, Watertown Memorial Hospital in Watertown, Wisconsin is deemed to be located in Jefferson County, Wisconsin.

(3) EFFECTIVE DATE.—This section, and the amendments made by paragraph (1), shall apply to discharges occurring on or after October 1, 1988.

(b) EXPANSION OF SWING-BED PROGRAM.—

(1) EXPANSION TO HOSPITALS WITH FEWER THAN 100 BEDS.—Section 1883(b)(1) of the Social Security Act (42 U.S.C. 1395tt(b)(1)) is amended by striking "50 beds" and inserting "100 beds".

(2) REQUIREMENTS FOR HOSPITALS WITH MORE THAN 49 BEDS.—Section 1883(d) of such Act (42 U.S.C. 1395dd(d)) is amended—

(A) by inserting "(1)" after "(d)", and

(B) by adding at the end the following new paragraphs:

"(2)(A) Any agreement under this section with a hospital with more than 49 beds shall provide that no payment may be made for extended care services which are furnished to an extended care patient after the end of the 5-day period (excluding weekends and holidays) beginning on an availability date for a skilled nursing facility, unless the patient's physician certifies, within such 5-day period, that the transfer of that patient to that facility is not medically appropriate on the availability date. The Secretary shall prescribe regulations to provide for notice by skilled nursing facilities of availability dates to hospitals which have agreements under this section and which are located within the same geographic region (as defined by the Secretary).

"(B) In this paragraph:

"(i) The term 'availability date' means, with respect to an extended care patient at a hospital, any date on which a bed is available for the patient in a skilled nursing facility located within the geographic region in which the hospital is located.

"(ii) The term 'extended care patient' means an individual being furnished extended care services at a hospital pursuant to an agreement with the Secretary under this section.

"(3) In the case of an agreement for a cost reporting period under this section with a hospital that has more than 49 beds, payment may not be made in the period for patient-days of extended care services that exceed 15 percent of the product of the number of days in the period and the average number of licensed beds in the hospital in the period.".

(3) REPORT.—The Secretary of Health and Human Services shall report to Congress, not later than February 1, 1989, concerning—

(A) the proportion of admissions to hospitals for extended care services under section 1883 of the Social Security Act which are denied or approved by a peer review organization under section 1154(a)(1) of such Act, and

(B) on recommendations for methods of encouraging hospitals that—

(i) have a low occupancy rate,

(ii) are eligible to enter (but have not entered) into an agreement under section 1883 of such Act, and

(iii) are located in areas with a need for additional providers of extended care services,

to enter into such agreements.

(4) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall apply to agreements under section 1883 of the Social Security Act entered into after March 31, 1988.

(c) PAYMENTS TO SOLE COMMUNITY HOSPITALS.—

(1) Section 1886(d)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(C)(ii)) is amended—

(A) by striking "1988" in the second sentence and inserting "1990", and

(B) by inserting after the second sentence the following: "A subsection (d) hospital that meets the criteria for classification as a sole community hospital and otherwise qualifies for the adjustment authorized by the preceding sentence may qualify for such an adjustment without regard to the formula by which payments are determined for the hospital under paragraph (1)(A).".

(2)(A) The amendments made by paragraph (1) shall apply to cost reporting periods beginning on or after October 1, 1987.

(B) The Secretary of Health and Human Services shall take appropriate steps to ensure that the total amount paid in a fiscal year under title XVIII of the Social Security Act by reason of the amendment made by paragraph (1)(B) does not exceed $5,000,000 in the case of fiscal year 1988 and $10,000,000 for fiscal year 1989.

(d) MEDICARE CLASSIFICATION OF RURAL REFERRAL CENTERS.—

(1) EXTENSION OF CLASSIFICATION.—

(A) IN GENERAL.—The first sentence of section 1886(d)(5)(C)(i)(I) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(C)(i)(I)) is amended by striking "500" and inserting "275".

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply to discharges occurring on or after April 1, 1988.

(2) STUDY.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall provide for a study of the criteria used for the classification of hospitals as rural referral centers under section 1886(d)(5)(C)(i) of the Social Security Act. The study shall include an examination of—

(i) the extent that hospitals classified as rural referral centers receive more or less than their actual costs of providing inpatient hospital services, and

(ii) the appropriateness of providing for payment for such centers at a rate other than the rate for a hospital located in an other urban area.

(B) REPORT.—The Secretary shall report to Congress, by not later than March 1, 1989, on the study conducted under subparagraph (A) and on recommendations for the criteria that should be applied under section 1886(d)(5)(C)(i) of the Social Security Act for the classification of hospitals as rural referral centers for cost reporting periods beginning on or after October 1, 1989.

(e) GRANT PROGRAM FOR RURAL HEALTH CARE TRANSITION.—

(1) The Administrator of the Health Care Financing Administration, in consultation with the Assistant Secretary for Health (or a designee), shall establish a program of grants to assist eligible small rural hospitals and their communities in the planning and implementation of projects to modify the type and extent of services such hospitals provide in order to adjust for one or more of the following factors:

(A) Changes in clinical practice patterns.

(B) Changes in service populations.

(C) Declining demand for acute-care inpatient hospital capacity.

(D) Declining ability to provide appropriate staffing for inpatient hospitals.

(E) Increasing demand for ambulatory and emergency services.

(F) Increasing demand for appropriate integration of community health services.

(G) The need for adequate access (including appropriate transportation) to emergency care and inpatient care in areas in which a significant number of underutilized hospital beds are being eliminated.

(H) The Administrator shall submit a final report on the program to the Congress not later than 180 days after all projects receiving a grant under the program are completed.

Each demonstration project under this subsection shall demonstrate methods of strengthening the financial and managerial capability of the hospital involved to provide necessary services. Such methods may include programs of cooperation with other health care providers, of diversification in services furnished (including the provision of home health services), of physician recruitment, and of improved management systems.

(2) For purposes of this subsection, the term "eligible small rural hospital" means any non-Federal, short-term general acute care hospital that—

(A) is located in a rural area (as determined in accordance with subsection (d)),

(B) has less than 100 beds, and

(C) is not for profit.

(3)(A) Any eligible small rural hospital that desires to modify the type or extent of health care services that it provides in order to adjust for one or more of the factors specified in paragraph (1) may submit an application to the Governor of the State in which it is located. The application shall specify the nature of the project proposed by the hospital, the data and information on which the project is based, and a timetable (of not more than 24 months) for completion of the project. The application shall be submitted on or before a date specified by the Administrator and shall be in such form as the Administrator may require.

(B) The Governor shall transmit any application submitted pursuant to subparagraph (A) to the Secretary not later than 30 days after it is received by the Governor, accompanied by any comments with respect to the application that the Governor deems appropriate.

(C) The Governor of a State may designate an appropriate State agency to receive and comment on applications submitted under subparagraph (A).

(4) A hospital shall be considered to be located in a rural area for purposes of this subsection if it is treated as being located in a rural area for purposes of section 1886(d)(3)(D) of the Social Security Act.

(5) In determining which hospitals making application under paragraph (3) will receive grants under this subsection, the Administrator shall take into account—

(A) any comments received under paragraph (3)(B) with respect to a proposed project;

(B) the effect that the project will have on—

(i) reducing expenditures from the Federal Hospital Insurance Trust Fund,

(ii) improving the access of medicare beneficiaries to health care of a reasonable quality;

(C) the extent to which the proposal of the hospital, using appropriate data, demonstrates an understanding of—

(i) the primary market or service area of the hospital, and

(ii) the health care needs of the elderly and disabled that are not currently being met by providers in such market or area, and

(D) the degree of coordination that may be expected between the proposed project and—

(i) other local or regional health care providers, and

(ii) community and government leaders,

as evidenced by the availability of support for the project (in cash or in kind) and other relevant factors.

(6) A grant to a hospital under this subsection may not exceed $50,000 a year and may not exceed a term of 2 years.

(7)(A) Except as provided in subparagraphs (D) and (C), a hospital receiving a grant under this subsection may use the grant

for any of expenses incurred in planning and implementing the project with respect to which the grant is made.

(B) A hospital receiving a grant under this subsection for a project may not use the grant to retire debt incurred with respect to any capital expenditure made prior to the date on which the project is initiated.

(C) Not more than one-third of any grant made under this subsection may be expended for capital-related costs (as defined by the Secretary for purposes of section 1886(a)(4) of the Social Security Act) of the project.

(8)(A) A hospital receiving a grant under this section shall furnish the Administrator with such information as the Administrator may require to evaluate the project with respect to which the grant is made and to ensure that the grant is expended for the purposes for which it was made.

(B) The Administrator shall report to the Congress at least once every 6 months on the program of grants established under this subsection. The report shall assess the functioning and status of the program, shall evaluate the progress made toward achieving the purposes of the program, and shall include any recommendations the Secretary may deem appropriate with respect to the program. In preparing the report, the Secretary shall solicit and include the comments and recommendations of private and public entities with an interest in rural health care.

(C) The Administrator shall submit a final report on the program to the Congress not later than 180 days after all projects receiving a grant under the program are completed.

(9) For purposes of carrying out the program of grants under this subsection, there are authorized to be appropriated from the Federal Hospital Insurance Trust Fund $15,000,000 for each of the fiscal years 1989 and 1990.

SEC. 4006. PAYMENTS FOR HOSPITAL CAPITAL.

(a) REDUCTIONS IN PAYMENTS FOR CAPITAL.—Section 1886(g)(3)(A) of the Social Security Act (42 U.S.C. 1395ww(g)(3)(A)) is amended—

(A) in clause (ii), by striking ", and" and inserting "on or after October 1, 1987, and before January 1, 1988,",

(B) by striking clause (iii) and inserting the following:

"(iii) 12 percent for payments attributable to portions of cost reporting periods or discharges (as the case may be) in fiscal year 1988, occurring on or after January 1, 1988, and

"(iv) 15 percent to portions of cost reporting periods or discharges (as the case may) be occuring during fiscal year 1989.".

(b) PROSPECTIVE PAYMENT FOR CAPITAL-RELATED COSTS.—

(1) IN GENERAL.—Paragraph (1) of section 1886(g) of such Act (42 U.S.C. 1395 ww (g)) is amended to read as follows:

"(g)(1)(A) Notwithstanding section 1861(v), instead of any amounts that are otherwise payable under this title with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary shall, for hospital cost reporting periods beginning on or after October 1, 1991, provide for payments for such costs in accordance with a prospective payment system established by the Secretary.

"(B) Such system—

"(i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;

"(ii) may provide for an adjustment to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located;

"(iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

"(iv) may provide for suitable adjustment to reflect hospital occupancy rate.

"(C) In this paragraph, the term 'capital-related costs' has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.".

(2) CONFORMING AMENDMENT.—Section 1886 of such Act is amended—

(A) in subsection (a)(4), by striking "with respect to costs incurred in cost reporting periods beginning prior to October 1 of 1987 (or of such later year as the Secretary may, in his discretion, select), other capital-related costs, as defined by the Secretary" and inserting "other capital-related costs (as defined by the Secretary for periods before October 1, 1987)", and

(B) by striking subparagraph (C) of subsection (g)(3).

(3) EFFECTIVE DATES.—The amendment made by paragraph (1) shall take effect on October 1, 1987. The amendments made by paragraph (2) shall apply to cost reporting periods beginning on or after October 1, 1987.

(c) PROPAC REPORT ON ADJUSTMENT FOR HOSPITAL OCCUPANCY.—The Prospective Payment Assessment Commission shall study and report to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate, by not later than May 1, 1988, on the suitability and feasibility of linking payment for capital-related costs under part A of title XVIII of the Social Security Act to hospital occupancy rates.

SEC. 4007. REPORTING HOSPITAL INFORMATION.

(a) DEVELOPMENT OF DATA BASE.—The Secretary of Health and Human Services, (in this section referred to as the "Secretary") shall develop and place into effect not later than June 1, 1989, a data base of the operating costs of inpatient hospital services with respect to all hospitals under title XVIII of the Social Security Act, which data base shall be updated at least once every quarter (and maintained for the 12-month period preceding any such update). The data base under this subsection may include data from preliminary cost reports (but the Secretary shall make available an updata analysis of the differences between preliminary and settled cost reports).

(b) REPORTING OF INFORMATION ELECTRONICALLY.—Subject to paragraph (2), with respect to hospital cost reporting periods beginning on or after October 1, 1989, the Secretary shall place into effect a standardized electronic cost reporting format for hospitals under the medicare program.

(2) The Secretary may delay or waive the implementation of such format in particular instances where such implementation would result in financial hardship (in particular with respect to a small percentage of medicare volume).

(c) DEMONSTRATION PROJECT.—

(1) The Secretary of Health and Human Services shall provide for a 3-year demonstration project to develop, and determine the costs and benefits of establishing a uniform system for the reporting by medicare participating hospitals of balance sheet and information described in paragraph (2). In contracting the project, the Secretary shall require hospitals in at least 2 States, one of which maintains a uniform hospital reporting system, to report such information based on standard information established by the Secretary.

(2) The information described in this paragraph is as follows:

(A) Hospital discharges (classified by category of service and by class of primary payer).

(B) Patient days (classified by category of service and by class of primary payer).

(C) Licensed beds, staffed beds, and occupancy (by category of service).

(D) Outpatient visits (classified by class of primary payer).

(E) Inpatient charges and revenues (classified by class of primary payer).

(F) Outpatient charges and revenues (classified by class of primary payer).

(G) Inpatient and outpatient hospital expenses (by cost-center classified for operating and capital).

(H) Reasonable costs.

(I) Other income.

(J) Uncompensated care (classified by bad debt and charity care).

(K) Capital acquisitions.

(L) Capital assets.

(3) The Secretary shall develop the system under subsection (c) in a manner so as—

(A) to facilitate the submittal of the information in the report in an electronic form, and

(B) to be compatible with the needs of the medicare prospective payment system.

(4) The Secretary shall prepare and submit, to the Prospective Payment Assessment Commission, the Comptroller General, the Committee on Ways and Means of the House of Representatives, and the Committee on Finance of the Senate, by not later than 45 days after the end of each calendar quarter, data collected under the system.

(5) In paragraph (3):

(A) The terms "bad debt" and "charity care" have such meanings as the Secretary establishes.

(B) The term "class" means, with respect to payers, the programs under this title VIII of the Social Security Act, a State plan approved under title XIX of such Act, other third party-payers, and self-paying individuals.

(7) The Secretary shall set aside at least $1,000,000 for each of fiscal years 1988, 1989, and 1990 from existing research funds to develop the format, according to paragraph (1), and at least $2,000,000 from program operations funds for data collection and analysis, but total funds shall not exceed $15,000,000 over 3 years.

(8) The Comptroller General shall analyze the adequacy of the existing system for reporting of hospital information and the costs and benefits of data reporting under the demonstration system and will recommend improvements in hospital data collection and in analysis and display of data in support of policy making.

(d) CONSULTATION.—The Secretary shall consult representatives of the hospital industry in carrying out the provisions of this section.

SEC. 4008. OTHER PROVISIONS RELATING TO PAYMENT FOR INPATIENT HOSPITAL SERVICES.

(a) MASSACHUSETTS MEDICARE REPAYMENT.—The Secretary of Health and Human Services shall not, on or after the date of the enactment of this Act, and before January 1, 1989, recoup from, or otherwise reduce payments to, hospitals in the State of Massachusetts because of alleged overpayments to such hospitals under part A of title XVIII of the Social Security Act which occurred during the period of the statewide hospital reimbursement demonstration project conducted in that State, between October 1, 1982, and June 30, 1986, under section 402 of the Social Security Amendments of 1967 and section 222 of the Social Security Amendments of 1972.

(b) CLARIFICATION OF SECTION 1814(b) STATE WAIVER AUTHORITY.—

(1) APPLICATION OF AGGREGATE TEST.—Section 1814(b)(3)(B) of the Social Security Act (42 U.S.C. 1395f(b)(3)(B)) is amended by striking "rate of increase for the previous three-year period" and inserting "aggregate rate of increase from October 1, 1983, to the most recent date for which annual data are available".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

(c) CONTINUATION OF BAD DEBT RECOGNITION FOR HOSPITAL SERVICES.—In making payments to hospitals under title XVIII of the Social Security Act, the Secretary of Health and Human Services shall not make any change in the policy in effect on August 1, 1987, with respect to payment under title XVIII of the Social Security Act to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under such title (including criteria for what constitutes a reasonable collection effort).

(d) HOSPITAL OUTLIER PAYMENTS AND POLICY.—

(1) INCREASE IN OUTLIER PAYMENTS FOR BURN CENTER DRGS.—

(A) IN GENERAL.—For discharges classified in diagnosis-related groups relating to burn cases and occurring on or after April 1, 1988, and before October 1, 1989, the marginal cost of care permitted by the Secretary of Health and Human Services under section 1886(d)(5)(A)(iii) of the Social Security Act shall be 90 percent of the appropriate

per diem cost of care or 90 percent of the cost for cost outliers.

(B) BUDGET NEUTRALITY.—Subparagraph (A) shall be implemented in a manner that ensures that total payments under section 1886 of the Social Security Act are not increased or decreased by reason of the adjustments required by such subparagraph.

(2) LIMITATION ON CHANGES IN OUTLIER REGULATIONS.—

(A) IN GENERAL.—Notwithstanding any other provision of law, except as required to implement specific provisions required under statute, the Secretary of Health and Human Services is not authorized to issue in final form, after the date of the enactment of this Act and before September 1, 1988, any final regulation which changes the method of payment for outlier cases under section 1886(d)(5)(A) of the Social Security Act.

(B) PROPAC REPORT.—The chairman of the Prospective Payment Assessment Commission shall report to the Congress and the Secretary of Health and Human Services, by not later than June 1, 1988, on the method of payment for outlier cases under such section and providing more adequate and appropriate payments with respect to burn outlier cases.

(3) REPORT ON OUTLIER PAYMENTS.—The Secretary of Health and Human Services shall include in the annual report submitted to the Congress pursuant to section 1875(b) of the Social Security Act a comparison with respect to hospitals located in an urban area and hospitals located in a rural area in the amount of reductions under section 1886(d)(3)(B) of the Social Security Act and additional payments under section 1886(d)(5)(A) of such Act.

(e) MISCELLANEOUS ACCOUNTING PROVISION.—Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986, subsection (d) of section 9307 of such Act is amended to read as follows:

"(d) MISCELLANEOUS ACCOUNTING PROVISION.—Notwithstanding any other provision of law, for purposes of section 1886(d)(1)(A) of the Social Security Act, in the case of a hospital that—

"(1) had a cost reporting period beginning on September 28, 29, or 30 of 1985,

"(2) is located in a State in which inpatient hospital services were paid in fiscal year 1985 pursuant to a Statewide demonstration project under section 402 of the Social Security Amendments of 1967 and section 222 of the Social Security Amendments of 1972, and

"(3) elects, by notice to the Secretary of Health and Human Services by not later than April 1, 1988, to have this subsection apply,

during the first 7 months of such cost reporting period the 'target percentage' shall be 75 percent and the 'DRG percentage' shall be 25 percent, and during the remaining 5 months of such period the 'target percentage' and the 'DRG percentage' shall each be 50 percent.".

SEC. 4009. MISCELLANEOUS PROVISIONS.

(a) RESPONSIBILITIES OF MEDICARE HOSPITALS IN EMERGENCY CASES.—

(1) INCREASE IN CIVIL MONETARY PENALTY.—Section 1867(d)(2) of the Social Security Act (42 U.S.C. 1395dd(d)(2)) is amended by striking "$25,000" and inserting "$50,000".

(2) EXCLUSION FROM MEDICARE PROGRAM FOR VIOLATIONS.—Section 1867(d)(1) of such Act is amended by adding at the end the following new sentence:

"If a civil money penalty is imposed on a responsible physician under paragraph (2), the Secretary may impose the sanction described in section 1842(j)(2)(A) (relating to barring from participation in the medicare program) in the same manner as it is imposed under section 1842(j).".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to actions occurring on or after the date of the enactment of this Act.

(b) DESIGNATION OF PEDIATRIC HOSPITALS AS MEETING CERTIFICATION AS HEART TRANSPLANT FACILITY.—For purposes of determining whether a pediatric hospital that performs pediatric heart transplants meets the criteria established by the Secretary of Health and Human Services for facilities in which the heart transplants performed will be considered to meet the requirement of section 1862(a)(1)(A) of the Social Security Act, the Secretary shall treat such a hospital as meeting such criteria if—

(1) the hospital's pediatric heart transplant program is operated jointly by the hospital and another facility that meets such criteria,

(2) the unified program shares the same transplant surgeons and quality assurance program (including oversight committee, patient protocol, and patient selection criteria), and

(3) the hospital demonstrates to the satisfaction of the Secretary that it is able to provide the specialized facilities, services, and personnel that are required by pediatric heart transplant patients.

(c) WAIVER OF INPATIENT LIMITATIONS FOR THE CONNECTICUT HOSPICE.—Subsection (a) of section 9307 of the Omnibus Budget Reconciliation Act of 1986 is amended—

(1) by striking "TEMPORARY" in the heading, and

(2) by striking "for hospice care provided before October 1, 1988,".

(d) REVISION OF APPOINTMENT PROCESS FOR PROSPECTIVE PAYMENT ASSESSMENT COMMISSION.—

(1) IN GENERAL.—Section 1886(e)(6)(B) of the Social Security Act (42 U.S.C. 1395ww(e)(6)(B)) is amended—

(A) in the first sentence, by striking "provide expertise and experience in the provision and financing of health care" and inserting "include individuals with national recognition for their expertise in health economics, hospital reimbursement, hospital financial management, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives,"; and

(B) by striking the last sentence.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to appointments made after the date of the enactment of this Act.

(e) PSYCHOLOGISTS' SERVICES FURNISHED TO HOSPITAL INPATIENTS.—

(1) IN GENERAL.—Section 1861(b)(3) of such Act (42 U.S.C. 1395x(b)(3)) is amended by inserting "(including clinical psychologist (as defined by the Secretary))" after "others" the first place it appears.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to services furnished on or after April 1, 1988.

(f) HOSPITAL CONDITION OF PARTICIPATION RELATED TO INDIVIDUAL RESPONSIBLE FOR CARE OF PATIENT.—Section 1861(e)(4) of such Act (42 U.S.C. 1395x(e)(4)) is amended by inserting "with respect to whom payment may be made under this title" after "patient".

(g) DELAY IN REQUIREMENTS RELATING TO HOSPITAL STANDARDS FOR ORGAN TRANSPLANTS AND STANDARDS FOR ORGAN PROCUREMENT AGENCIES.—

(1) Section 9318(b)(2) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 107(c) of the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987, is amended by striking "November 21, 1987" and inserting "March 31, 1988".

(2) The amendment made by paragraph (1) shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986.

(h) PROPAC STUDIES AND REPORTS.—

(1) PROPAC REPORTS ON STUDY OF DRG RATES FOR HOSPITALS IN RURAL AND URBAN AREAS.—The Prospective Payment Assessment Commission shall evaluate the study conducted by the Secretary of Health and Human Services pursuant to section 603(a)(2)(C)(i) of the Social Security Amendments of 1983 (relating to the feasibility, impact, and desirability of eliminating or phasing out separate urban and rural DRG prospective payment rates) and report its conclusions and recommendations to the Congress not later than March 1, 1988.

(2) PROPAC REPORT ON SEPARATE URBAN PAYMENT RATES.—The Prospective Payment Assessment Commission shall evaluate the desirability of maintaining separate DRG prospective payment rates for hospitals located in large urban areas (as defined in section 1886(d)(2)(D)) of the Social Security Act) and in other urban areas, and shall report to Congress on such evaluation not later than January 1, 1989.

(3) REPORT ON ADJUSTMENT FOR NON-LABOR COSTS.—The Prospective Payment Assessment Commission shall perform an analysis to determine the feasibility and appropriateness of adjusting the non-wage-related portion of the adjusted average standardized amounts under section 1886(d)(3) of the Social Security Act based on area differences in hospitals' costs (other than wage-related costs) and input prices. The Commission shall report to the Congress on such analysis by not later than October 1, 1989.

(i) SPECIAL RULE.—In the case of New England county metropolitan areas, the Secretary of Health and Human Services shall apply the second sentence of section 1886(d)(2)(D) of the Social Security Act, as amended by section 4001(b) of this subtitle, as though 970,000 were substituted for 1,000,000.

(j) TECHNICAL CORRECTIONS.—

(1) Section 1886(a)(4) of the Social Security Act (42 U.S.C. 1395ww(a)(4)) is amended by inserting a comma after "educational activities".

(2) Section 1886(d)(5)(C)(i)(II) of such Act (42 U.S.C. 1395ww(d)(5)(C)(i)(II)) is amended by inserting "index" after "case mix" both places it appears.

(3) Section 1886(d)(5)(F) of such Act (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(A) in clause (i)(II), by striking "such revenues" the second place it appears and inserting "such net inpatient care revenues", and

(B) in clause (iv)(I), by striking "subclause (III)" and inserting "clause (v)".

(4) Section 1886(d)(9) of such Act (42 U.S.C. 1395ww(d)(9)) is amended by moving the matter in subparagraph (B) before clause (i) 2 ems to the left so the left margin of such matter is aligned with the left margin of the matter in subparagraph (A) before clause (i).

(5) Section 1886(h)(4)(C) of such Act (42 U.S.C. 1395ww(h)(4)(C)) is amended by striking "subparagraph (E)" and inserting "subparagraph (D)".

(6) Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986—

(A) subparagraph (B) of section 9307(c)(1) of such Act is amended to read as follows:

"(B) in paragraph (2)—

"(i) by striking subparagraphs (A) and (B),

"(ii) in subparagraph (C), by striking 'such subsection' and inserting 'of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)' and by redesignating such subparagraph as subparagraph (A), and

"(iii) by amending subparagraph (D) to read as follows:

" '(B) The amendments made by subparagraph (A) apply to discharges occurring on or after May 1, 1986.' ";

(B) section 9302(a)(2)(C) of such Act is amended by striking "1866(e)(5)" and inserting "1886(e)(5)";

(C) section 9320(h)(1) of such Act is amended by striking "before the period" and inserting "before the semicolon";

(D) section 9321(c)(4) of such Act is amended by striking "second sentence" and all that follows through "operating costs" and inserting "second sentence of section 1886(a)(4) of the Social Security Act, from the term 'operating costs";

(E) the second sentence of section 9335(d)(2) of such Act is amended by striking "establish" and inserting "designate"; and

(F) section 9321(c)(3) of such Act is amended by inserting "section 1861(v)(1)(O) and 1886(g)(2) of the Social Security Act and" after "implementing".

(7) Section 218(v) of the Social Security Act (42 U.S.C. 418(v)) is amended by striking paragraph (3).

(8) Effective as if included in the Tax Reform Act of 1986, section 1895(d)(6)(C) of such Act is amended by striking "603" and inserting "2203".

PART 2—PROVISIONS RELATING TO PARTS A & B

Subpart A—Health Maintenance Organization Reforms

SEC. 4011. BENEFICIARY PROTECTION.

(a) POST-CONTRACT PROTECTION FOR ENROLLEES WITH ELIGIBLE ORGANIZATIONS UNDER THE MEDICARE PROGRAM.—

(1) Section 1876(c)(3) of such Act (42 U.S.C. 1395mm(b)(2)) is amended by adding at the end the following new subparagraph:

"(F) Each eligible organization that provides items and services pursuant to a contract under this section shall provide assurances to the Secretary that in the event the organization ceases to provide such items and services, the organization shall provide or arrange for supplemental coverage of benefits under this title related to a pre-existing condition with respect to any exclusion period, to all individuals enrolled with the entity who receive benefits under this title, for the lesser of six months or the duration of such period.".

(2) The amendment made by paragraph (1) shall apply with respect to contracts entered into or renewed on or after the date of enactment of this Act.

(b) NOTIFICATION OF TERMINATION OF RISK-SHARING CONTRACT.—

(1) Section 1876(c)(3) of such Act, as amended by subsection (a)(1), is further amended by adding at the end the following new subparagraph:

"(G)(i) Each eligible organization having a risk-sharing contract under this section shall notify individuals eligible to enroll with the organization under this section and individuals enrolled with the organization under this section that—

"(I) the organization is authorized by law to terminate or refuse to renew the contract, and

"(II) termination or nonrenewal of the contract may result in termination of the enrollments of individuals enrolled with the organization under this section.

"(ii) The notice required by clause (i) shall be included in—

"(I) any marketing materials described in subparagraph (C) that are distributed by an eligible organization to individuals eligible to enroll under this section with the organization, and

"(II) any explanation provided to enrollees by the organization pursuant to subparagraph (E).".

(2) The amendment made by paragraph (1) shall apply to contracts entered into or renewed on or after the date of the enactment of this Act.

SEC. 4012. PAYMENTS FOR HOSPITAL SERVICES.

(a) IN GENERAL.—Section 1866(a)(1) of such Act (42 U.S.C. 1395cc(a)(1)) is amended by inserting immediately after subparagraph (N) the following new subparagraph:

"(O) in the case of hospitals and skilled nursing facilities, to accept as payment in full for inpatient hospital and extended care services that are covered under this title and are furnished to any individual enrolled with an eligible organization with a risk-sharing contract under section 1876 the amounts (in the case of hospitals) or limits (in the case of skilled nursing facilities) that would be made as a payment in full under this title if the individuals were not so enrolled.".

(b) REPEAL.—Section 1876(g)(4) of the Social Security Act (42 U.S.C. 1395mm(g)(4)) is repealed.

(c) IMPLEMENTATION.—The Secretary of Health and Human Services shall provide (in machine readable form) to eligible organizations under section 1876 of the Social Security Act medicare DRG rates for payments required by the amendment made by paragraph (2) and data on cost pass-through items for all inpatient services provided to medicare beneficiaries enrolled with such organizations.

(d) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to admissions occurring on or after April 1, 1988, or, if later, the earliest date the Secretary can provide the information required under subsection (c) in machine readable form.

SEC. 4013. TWO-YEAR EXTENSION ON PERIOD FOR BENEFIT STABILIZATION.

(a) IN GENERAL.—Section 1876(g)(5) of the Social Security Act (42 U.S.C. 1395mm(g)(5)), as added by the amendment made by section 2350(a)(2) of the Deficit Reduction Act of 1984, is amended by striking "four" and inserting "six".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall be effective as if included in the enactment of the amendment made by section 2350(a)(2) of the Deficit Reduction Act of 1984.

SEC. 4014. CIVIL MONEY PENALTIES AND INTERMEDIATE SANCTIONS AGAINST HMOS/CMPS.

Section 1876(i)(6) of the Social Security Act (42 U.S.C. 1395mm) is amended to read as follows:

"(6)(A) If the Secretary determines that an eligible organization with a contract under this section—

"(i) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

"(ii) imposes premiums on individuals enrolled under this section in excess of the premiums permitted;

"(iii) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this section;

"(iv) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this section) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

"(v) misrepresents or falsifies information that is furnished—
"(I) to the Secretary under this section, or
"(II) to an individual or to any other entity under this section; or
"(vi) fails to comply with the requirements of subsection (g)(6)(A);

the Secretary may provide for any of the remedies described in subparagraph (B).

"(B) The remedies described in this subparagraph are—
"(i) civil money penalties of not more than $25,000 for each determination under subparagraph (A) or, with respect to a determination under clause (iv) or (v)(I), of not more than $100,000 for each such determination,
"(ii) suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or
"(iii) suspension of payment to the organization under this section for individuals enrolled after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as they apply to a civil money penalty under that section.".

SEC. 4015. MEDICARE PAYMENT DEMONSTRATION PROJECTS.

(a) MEDICARE INSURED GROUP DEMONSTRATION PROJECTS.—

(1) The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") may provide for capitation demonstration projects (in this subsection referred to as "projects") with an entity which is an eligible organization with a contract with the Secretary under section 1876 of the Social Security Act or which meets the restrictions and requirements of this subsection. The Secretary may not approve a project unless it meets the requirements of this subsection.

(2) The Secretary may not conduct more than 3 projects and may not expend, from funds under title XVIII of the Social Security Act, more than $600,000,000 in any fiscal year for all such projects.

(3) The per capita rate of payment under a project—
(A) may be based on the adjusted average per capita cost (as defined in section 1876(a)(4) of the Social Security Act) determined only with respect to the group of individuals involved (rather than with respect to medicare beneficiaries generally), but
(B) the rate of payment may not exceed the lesser of—
(i) 95 percent of the adjusted average per capita cost described in subparagraph (A), or
(ii)(I) in the 4th year or 5th year of a project, 115 percent of the adjusted average per capita cost (as defined in section 1876(a)(4) of such Act) for classes of individuals described in section 1876(a)(1)(B) of that Act, or

(II) in any subsequent year of a project, 95 percent of the adjusted average per capita cost (as defined in section 1876(a)(4)) for such classes.

(4) If the payment amounts made to a project are greater than the the costs of the project (as determined by the Secretary or, if applicable, on the basis of adjusted community rates described in section 1876(e)(3) of the Social Security Act), the project—

(A) may retain the surplus, but not to exceed 5 percent of the average adjusted per capita cost determined in accordance with paragraph (3)(A), and

(B) with respect to any additional surplus not retained by the project, shall apply such surplus to additional benefits for individuals served by the project or return such surplus to the Secretary.

(5) Enrollment under the project shall be voluntary. Individuals enrolled with the project may terminate such enrollment as of the beginning of the first calendar month following the date on which the request is made for such termination. Upon such termination, such individuals shall retain the same rights to other health benefits that such individuals would have had if they had never enrolled with the project without any exclusion or waiting period for pre-existing conditions.

(6) The requirements of—

(A) subsection (c)(3)(C) (relating to dissemination of information),

(B) subsection (c)(3)(E) (annual statement of rights),

(C) subsection (c)(5) (grievance procedures),

(D) subsection (c)(6) (on-going quality),

(E) subsection (g)(6) (relating to prompt payment of claims),

(F) subsection (i)(3)(A) and (B) (relating to access to information and termination notices),

(G) subsection (i)(6) (relating to providing necessary services), and

(H) subsection (i)(7) (relating to agreements with peer review organizations),

of section 1876 of the Social Security Act shall apply to a project in the same manner as they apply to eligible organizations with risk-sharing contracts under such section.

(7) The benefits provided under a project must be at least actuarially equivalent to the combination of the benefits available under title XVIII of the Social Security Act and the benefits available through any alternative plans in which the individual can enroll through the the employer. The project shall guarantee the actuarial value of benefits available under the employer plan for the duration of the project.

(8) A project shall comply with all applicable State laws.

(9) The Secretary may not authorize a project unless the entity offering the project demonstrates to the satisfaction of the Secretary that it has the necessary financial reserves to pay for any liability for benefits under the project (including those liabilities for health benefits under medicare and any supplemental benefits).

(10) The Comptroller General shall monitor projects under this subsection and shall report periodically (not less often than once every year) to the Committee on Finance of the Senate and the Committee on Energy and Commerce and Committee on Ways and Means of the House of Representatives on the status of such projects and the affect on such projects of the requirements of this section and shall submit a final report to each such committee on the results of such projects.

(b) PAYMENT METHODOLOGY REFORM DEMONSTRATIONS PROJECTS.—

(1) The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") is specifically authorized to conduct demonstration projects under this subsection for the purpose of testing alternative payment methodologies pertaining to capitation payments under title XVIII of the Social Security Act, including—

(A) computing adjustments to the average per capita cost under section 1876 of such Act on the basis of health status or prior utilization of services, and

(B) accounting for geographic variations in cost in the adjusted average per capita costs applicable to an eligible organization under such section which differs from payments currently provided on a county-by-county basis.

(2) No project may be conducted under this subsection—

(A) with an entity which is not an eligible organization (as defined in section 1876(b) of the Social Security Act), and

(B) unless the project meets all the requirements of subsections (c) and (i)(3) of section 1876 of such Act.

(3) There are authorized to be appropriated to carry out projects under this subsection $5,000,000 in each of fiscal years 1989 and 1990.

(c) APPLICATION OF PROVISIONS.—The provisions of subsection (a)(2) and the first sentence of subsection (b) of section 402 of the Social Security Amendments of 1967 shall apply to the demonstration projects under this section in the same manner as they apply to experiments under subsection (a)(1) of that section.

SEC. 4016. DELAY IN EFFECTIVE DATE IN PHYSICIAN INCENTIVE RULES FOR HEALTH MAINTENANCE ORGANIZATIONS.

Section 9313(c)(2)(B) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking "April 1, 1989" and inserting "April 1, 1990".

SEC. 4017. GAO STUDY AND REPORTS ON MEDICARE CAPITATION.

(a) STUDY.—The Comptroller General shall conduct a study on medicare capitation rates that shall include an analysis and assessment of—

(1) the current method for computing per capita rates of payment under section 1876 of the Social Security Act (including the method for determining the United States per capita cost);

(2) the method for establishing relative costs for geographic areas and the data used to establish age, sex, and other weighting factors;

(3) ways to refine the calculation of adjusted average per capita costs under section 1876 of such Act (including making adjustments for health status or prior utilization of services and improvements in the definition of geographic areas);

(4) the extent to which individuals enrolled with organizations with a risk-sharing contract with the Secretary under section 1876 of such Act differ in utilization and cost from fee-for-service beneficiaries and ways for modifying enrollment patterns through program changes or for reflecting the differences in rates through group experience rating or other means;

(5) approaches for limiting the liability of the contracting organization under section 1876 of such Act in catastrophic cases;

(6) ways of establishing capitation rates on a basis other than fee-for-service experience in areas with high prepaid market penetration; and

(7) methods for providing the rate levels necessary to maintain access to quality prepaid services in rural or medically underserved areas (while maintaining cost savings).

(b) REPORTS.—

(1) Not later than January 1 of 1989 and 1990, the Comptroller General shall submit to the Committee on Finance of the Senate and the Committee on Energy and Commerce and Committee on Ways and Means of the House of Representatives interim reports on the progress of the study conducted under subsection (a).

(2) Not later than January 1, 1991, the Comptroller General shall submit to each such committee a final report on the results of such study.

SEC. 4018. SPECIAL RULES.

(a) ASSIGNMENT OF MEMBERS FOR HIP HEALTH MAINTENANCE ORGANIZATION.—Section 1876(f) of such Act (42 U.S.C. 1395mm(f)) is amended by redesignating paragraph (3) as paragraph (4) and by inserting after paragraph (2) the following new paragraph:

"(3)(A) An eligible organization described in subparagraph (B) may elect, for purposes of determining the compliance of a subdivision, subsidiary, or affiliate described in subparagraph (B)(iii) with the requirement of paragraph (1) for the period before October 1, 1992, to have members of the subdivision, subsidiary, or affiliate considered to be members of the parent organization.

"(B) An eligible organization described in this subparagraph is an eligible organization which—

"(i) is described in section 1903(m)(2)(B)(iii);

"(ii) has members who have a collectively bargained contractual right to obtain health benefits from the organization;

"(iii) elects to provide benefits under a risk-sharing contract to individuals residing in a service area, who have a collectively bargained contractual right to obtain benefits from the organization, through a subdivision, subsidiary, or affiliate which itself is an eligible organization serving the area and which is owned or controlled by the parent eligible organization; and

"(iv) has assumed any risk of insolvency and quality assurance with respect to individuals receiving benefits through such a subdivision, subsidiary, or affiliate.".

(b) EXTENSION OF WAIVERS FOR SOCIAL HEALTH MAINTENANCE ORGANIZATIONS.—

(1) The Secretary of Health and Human Services shall extend without interruption, through September 30, 1992, the approval of waivers granted under subsection (a) of section 2355 of the Deficit Reduction Act of 1984 for the demonstration project described in subsection (b) of that section, subject to the terms and conditions (other than duration of the project) established under that section (as amended by paragraph (2) of this subsection).

(2) Section 2355(b)(5) of the Deficit Reduction Act of 1984 is amended by inserting "and in succeeding years" after "third year".

(3) Section 2355(d)(2) of the Deficit Reduction Act of 1984 is amended by striking "final" and inserting "interim".

(4) The Secretary of Health and Human Services shall submit a final report to the Congress on the project referred to in paragraph (1) not later than March 31, 1993.

(c) TREATMENT OF MICHIGAN BLUE CARE HMO NETWORK UNDER 50 PERCENT RULE.—Blue Care, Inc., a nonprofit corporation which is indirectly owned and operated by Blue Cross and Blue Shield of Michigan, Inc. and which enrolls individuals for the purpose of providing them with health care services through assignment to health maintenance organizations which are indirectly or wholly owned and operated by Blue Cross and Blue Shield of Michigan, Inc., is deemed to meet the requirement of section 1876(f)(1) of the Social Security Act (relating to limitation on enrollment of medicare and medicaid beneficiaries with an eligible organization) if—

(1) such requirement would be met if applied to all individuals enrolled with (or otherwise assigned to) each of such health maintenance organizations, and

(2) not more than 20 percent of the number of individuals who are members of (or otherwise assigned to) each such organization consists of individuals who are entitled to benefits under title XVIII of the Social Security Act.

(d) TEMPORARY WAIVER FOR WATTS HEALTH FOUNDATION.—Section 9312(c)(3) of the Omnibus Budget Reconciliation Act of 1986 is amended by adding at the end the following new subparagraph:

"(D) TREATMENT OF CERTAIN WAIVERS.—In the case of an eligible organization (or successor organization) that is described in clauses (i) and (ii) of subparagraph (C) and that received a grant or grants totaling at least $3,000,000 in fiscal year 1987 under section 329(d)(1)(A) or 330(d)(1) of the Public Health Service Act—

"(i) before January 1, 1990, section 1876(f) of the Social Security Act shall not apply to the organization;

"(ii) beginning on January 1, 1990, the Secretary of Health and Human Services shall waive the requirement of such section with respect to the organization if—

"(I) before such date, the organization has submitted to the Secretary a schedule for the organization to comply with the requirement of section 1876(f)(1) of such Act, and the Secretary has found

such schedule to be reasonable and has approved such schedule; and

"(II) periodically after such date, the Secretary reviews the organization's compliance with such schedule and determines that the organization has complied, or made significant progress towards compliance, with such schedule; and

"(iii) after January 1, 1990, if the Secretary has approved a schedule under clause (ii)(I) and has determined, in a periodic review under clause (ii)(II), that the organization has not complied, or made significant progress towards compliance, with such schedule, the Secretary may provide for a sanction described in section 1876(f)(3) of the Social Security Act effective with respect to individuals enrolling with the organization after the date the Secretary notifies the organization of such noncompliance.".

Subpart B—Home Health Quality

SEC. 4021. CONDITIONS OF PARTICIPATION FOR HOME HEALTH AGENCIES.

(a) DEFINITION OF HOME HEALTH AGENCY.—Section 1861(o)(6) of the Social Security Act (42 U.S.C. 1395x(o)(6)) is amended by inserting "the conditions of participation specified in section 1891(a) and" after "meets".

(b) CONDITIONS OF PARTICIPATION.—Title XVIII of such Act is amended by adding at the end the following new section:

"CONDITIONS OF PARTICIPATION FOR HOME HEALTH AGENCIES; HOME HEALTH QUALITY

"SEC. 1891. (a) The conditions of participation that a home health agency is required to meet under this subsection are as follows:

"(1) The agency protects and promotes the rights of each individual under its care, including each of the following rights:

"(A) The right to be fully informed in advance about the care and treatment to be provided by the agency, to be fully informed in advance of any changes in the care or treatment to be provided by the agency that may affect the individual's well-being, and (except with respect to an individual adjudged incompetent) to participate in planning care and treatment or changes in care or treatment.

"(B) The right to voice grievances with respect to treatment or care that is (or fails to be) furnished without discrimination or reprisal for voicing grievances.

"(C) The right to confidentiality of the clinical records described in section 1861(o)(3).

"(D) The right to have one's property treated with respect.

"(E) The right to be fully informed orally and in writing (in advance of coming under the care of the agency) of—

"(i) all items and services furnished by (or under arrangements with) the agency for which payment may be made under this title,

"(ii) the coverage available for such items and services under this title, title XIX, and any other Federal program of which the agency is reasonably aware,

"(iii) any charges for items and services not covered under this title and any charges the individual may have to pay with respect to items and services furnished by (or under arrangements with) the agency, and

"(iv) any changes in the charges or items and services described in clause (i), (ii), or (iii).

"(F) The right to be fully informed in writing (in advance of coming under the care of the agency) of the individual's rights and obligations under this title.

"(G) The right to be informed of the availability of the State home health agency hot-line established under section 1864(a).

"(2) The agency notifies the State entity responsible for the licensing or certification of the agency of a change in—

"(A) the persons with an ownership or control interest (as defined in section 1124(a)(3)) in the agency,

"(B) the persons who are officers, directors, agents, or managing employees (as defined in section 1126(b)) of the agency, and

"(C) the corporation, association, or other company responsible for the management of the agency.

Such notice shall be given at the time of the change and shall include the identity of each new person or company described in the previous sentence.

"(3)(A) The agency must not use as a home health aide (on a full-time, temporary, per diem, or other basis), any individual who is not a licensed health care professional (as defined in subparagraph (F)) to provide items or services described in section 1861(m) on or after January 1, 1990, unless the individual—

"(i) has completed a training and competency evaluation program, or a competency evaluation program, that meets the minimum standards established by the Secretary under subparagraph (D), and

"(ii) is competent to provide such items and services.

For purposes of clause (i), an individual is not considered to have completed a training and competency evaluation program, or a competency evaluation program if, since the individual's most recent completion of such a program, there has been a continuous period of 24 consecutive months during none of which the individual provided items and services described in section 1861(m) for compensation.

"(B)(i) The agency must provide, with respect to individuals used as a home health aide by the agency as of July 1, 1989, for a competency evaluation program (as described in subparagraph (A)(i)) and such preparation as may be necessary for the individual to complete such a program by January 1, 1990.

"(ii) The agency must provide such regular performance review and regular in-service education as assures that individ-

uals used to provide items and services described in section 1861(m) are competent to provide those items and services.

"(C) The agency must not permit an individual, other than in a training and competency evaluation program that meets the minimum standards established by the Secretary under subparagraph (D), to provide items or services of a type for which the individual has not demonstrated competency.

"(D)(i) The Secretary shall establish minimum standards for the programs described in subparagraph (A) by not later than October 1, 1988.

"(ii) Such standards shall include the content of the curriculum, minimum hours of training, qualification of instructors, and procedures for determination of competency.

"(iii) Such standards may permit approval of programs offered by or in home health agencies, as well as outside agencies (including employee organizations), and of programs in effect on the date of the enactment of this section; except that they may not provide for the approval of a program offered by or in a home health agency which has been determined to be out of compliance with the requirements specified in or pursuant to section 1861(o) or subsection (a) within the previous 2 years.

"(iv) Such standards shall permit a determination that an individual who has completed (before July 1, 1989) a training and competency evaluation program or a competency evaluation program shall be deemed for purposes of subparagraph (A) to have completed a program that is approved by the Secretary under the standards established under this subparagraph if the Secretary determines that, at the time the program was offered, the program met such standards.

"(E) In this paragraph, the term 'home health aide' means any individual who provides the items and services described in section 1861(m), but does not include an individual—

"(i) who is a licensed health professional (as defined in subparagraph (F)), or

"(ii) who volunteers to provide such services without monetary compensation.

"(F) In this paragraph, the term 'licensed health professional' means a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapist, registered professional nurse, licensed practical nurse, or licensed or certified social worker.

"(4) With respect to durable medical equipment furnished to individuals for whom the agency provides items and services, suppliers of such equipment do not use (on a full-time, temporary, per diem, or other basis) any individual who does not meet minimum training standards (established by the Secretary by October 1, 1988) for the demonstration and use of any such equipment furnished to individuals with respect to whom payments may be made under this title.

"(5) The agency includes an individual's plan of care required under section 1861(m) as part of the clinical records described in section 1861(o)(3).

"(6) The agency operates and provides services in compliance with all applicable Federal, State, and local laws and regula-

tions (including the requirements of section 1124) and with accepted professional standards and principles which apply to professionals providing items and services in such an agency.

"(b) It is the duty and responsibility of the Secretary to assure that the conditions of participation and requirements specified in or pursuant to section 1861(o) and subsection (a) of this section and the enforcement of such conditions and requirements are adequate to protect the health and safety of individuals under the care of a home health agency and to promote the effective and efficient use of public moneys.".

(c) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by subsections (a) and (b) shall apply to home health agencies as of the first day of the 18th calendar month that begins after the date of the enactment of this Act.

SEC. 4022. STANDARD AND EXTENDED SURVEY.

(a) IN GENERAL.—Section 1891 of the Social Security Act (as added by section 4021) is amended by adding at the end the following new subsections:

"(c)(1) Any agreement entered into or renewed by the Secretary pursuant to section 1864 relating to home health agencies shall provide that the appropriate State or local agency shall conduct, without any prior notice, a standard survey of each home health agency. Any individual who notifies (or causes to be notified) a home health agency of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The Secretary shall provide for imposition of civil money penalties under this clause in a manner similar to that for the imposition of civil money penalties under section 1128A. The Secretary shall review each State's or local agency's procedures for scheduling and conduct of standard surveys to assure that the State or agency has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

"(2)(A) Except as provided in subparagraph (B), each home health agency shall be subject to a standard survey not later than 15 months after the date of the previous standard survey conducted under this paragraph. The Statewide average interval between standard surveys of any home health agency shall not exceed 12 months.

"(B) If not otherwise conducted under subparagraph (A), a standard survey (or an abbreviated standard survey) of an agency—

"(i) may be conducted within 2 months of any change of ownership, administration, or management of the agency to determine whether the change has resulted in any decline in the quality of care furnished by the agency, and

"(ii) shall be conducted within 2 months of when a significant number of complaints have been reported with respect to the agency to the Secretary, the State, the entity responsible for the licensing of the agency, the State or local agency responsible for maintaining a toll-free hotline and investigative unit (under section 1864(a)), or any other appropriate Federal, State, or local agency.

"(C) A standard survey conducted under this paragraph with respect to a home health agency—

"(i) shall include (to the extent practicable), for a case-mix stratified sample of individuals furnished items or services by the agency—

"(I) visits to the homes of such individuals, but only with the consent of such individuals, for the purpose of evaluating (in accordance with a standardized reproducible assessment instrument (or instruments) approved by the Secretary under subsection (d)) the extent to which the quality and scope of items and services furnished by the agency attained and maintained the highest practicable functional capacity of each such individual as reflected in such individual's written plan of care required under section 1861(m) and clinical records required under section 1861(o)(3); and

"(II) a survey of the quality of care and services furnished by the agency as measured by indicators of medical, nursing, and rehabilitative care;

"(ii) shall be based upon a protocol that is developed, tested, and validated by the Secretary not later than January 1, 1989; and

"(iii) shall be conducted by an individual—

"(I) who meets minimum qualifications established by the Secretary not later than July 1, 1989,

"(II) who is not serving (or has not served within the previous 2 years) as a member of the staff of, or as a consultant to, the home health agency surveyed respecting compliance with the conditions of participation specified in or pursuant to section 1861(o) or subsection (a) of this section, and

"(III) who has no personal or familial financial interest in the home health agency surveyed.

"(D) Each home health agency that is found, under a standard survey, to have provided substandard care shall be subject to an extended survey to review and identify the policies and procedures which produced such substandard care and to determine whether the agency has complied with the conditions of participation specified in or pursuant to section 1861(o) or subsection (a) of this section. Any other agency may, at the Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey). The extended survey shall be conducted immediately after the standard survey (or, if not practical, not later than 2 weeks after the date of completion of the standard survey).

"(E) Nothing in this paragraph shall be construed as requiring an extended (or partial extended) survey as a prerequisite to imposing a sanction against an agency under subsection (e) on the basis of the findings of a standard survey.

"(d)(1) Not later than January 1, 1989, the Secretary shall designate an assessment instrument (or instruments) for use by an agency in complying with subsection (c)(2)(C)(I).

"(2)(A) Not later than January 1, 1991, the Secretary shall—

"(i) evaluate the assessment process,

"(ii) report to Congress on the results of such evaluation, and

"(iii) based on such evaluation, make such modifications in the assessment process as the Secretary determines are appropriate.

"(B) The Secretary shall periodically update the evaluation conducted under subparagraph (A), report the results of such update to Congress, and, based on such update, make such modifications in the assessment process as the Secretary determines are appropriate.

"(3) The Secretary shall provide for the comprehensive training of State and Federal surveyors in matters relating to the performance of standard and extended surveys under this section, including the use of any assessment instrument (or instruments) designated under paragraph (1).".

(b) EFFECTIVE DATE.—Except as otherwise specifically provided in section 1891(d) of the Social Security Act (as added by subsection (a)), the amendment made by subsection (a) shall become effective on the first day of the 18th calendar month to begin after the date of the enactment of this Act.

SEC. 4023. ENFORCEMENT.

Section 1891 of the Social Security Act (as added by section 4021 and amended by section 4022) is further amended by adding at the end the following new subsections:

"(e)(1) If the Secretary determines on the basis of a standard, extended, or partial extended survey or otherwise, that a home health agency that is certified for participation under this title is no longer in compliance with the requirements specified in or pursuant to section 1861(o) or subsection (a) and determines that the deficiencies involved immediately jeopardize the health and safety of the individuals to whom the agency furnishes items and services, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subsection (f)(2)(A)(iii) or terminate the certification of the agency, and may provide, in addition, for 1 or more of the other remedies described in subsection (f)(2)(A).

"(2) If the Secretary determines on the basis of a standard, extended, or partial extended survey or otherwise, that a home health agency that is certified for participation under this title is no longer in compliance with the requirements specified in or pursuant to section 1861(o) or subsection (a) and determines that the deficiencies involved do not immediately jeopardize the health and safety of the individuals to whom the agency furnishes items and services, the Secretary may (for a period not to exceed 6 months) impose intermediate sanctions developed pursuant to subsection (f), in lieu of terminating the certification of the agency. If, after such a period of intermediate sanctions, the agency is still no longer in compliance with the requirements specified in or pursuant to section 1861(o) or subsection (a), the Secretary shall terminate the certification of the agency.

"(3) If the Secretary determines that a home health agency that is certified for participation under this title is in compliance with the requirements specified in or pursuant to section 1861(o) or subsection (a) but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subsection

(f)(2)(A)(i) for the days in which it finds that the agency was not in compliance with such requirements.

"(4) The Secretary may continue payments under this title with respect to a home health agency not in compliance with the requirements specified in or pursuant to section 1861(o) or subsection (a) over a period of not longer than 6 months, if—

"(A) the State or local survey agency finds that it is more appropriate to take alternative action to assure compliance of the agency with the requirements than to terminate the certification of the agency,

"(B) the agency has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

"(C) the agency agrees to repay to the Federal Government payments received under this subparagraph if the corrective action is not taken in accordance with the approved plan and timetable.

The Secretary shall establish guidelines for approval of corrective actions requested by home health agencies under this subparagraph.

"(f)(1) The Secretary shall develop and implement, by not later than April 1, 1989—

"(A) a range of intermediate sanctions to apply to home health agencies under the conditions described in subsection (e), and

"(B) appropriate procedures for appealing determinations relating to the imposition of such sanctions.

"(2)(A) The intermediate sanctions developed under paragraph (1) shall include—

"(i) civil money penalties for each day of noncompliance,

"(ii) suspension of all or part of the payments to which a home health agency would otherwise be entitled under this title with respect to items and services furnished by a home health agency on or after the date on which the Secretary determines that intermediate sanctions should be imposed pursuant to subsection (e)(2), and

"(iii) the appointment of temporary management to oversee the operation of the home health agency and to protect and assure the health and safety of the individuals under the care of the agency while improvements are made in order to bring the agency into compliance with all the requirements specified in or pursuant to section 1861(o) or subsection (a).

The temporary management under clause (iii) shall not be terminated until the Secretary has determined that the agency has the management capability to ensure continued compliance with all the requirements referred to in that clause.

"(B) The sanctions specified in subparagraph (A) are in addition to sanctions otherwise available under State or Federal law and shall not be construed as limiting other remedies, including any remedy available to an individual at common law.

"(C) A finding to suspend payment under subparagraph (A)(ii) shall terminate when the Secretary finds that the home health agency is in substantial compliance with all the requirements specified in or pursuant to section 1861(o) and subsection (a).

"(3) The Secretary shall develop and implement, by not later than April 1, 1989, specific procedures with respect to the conditions under which each of the intermediate sanctions developed under paragraph (1) is to be applied, including the amount of any fines and the severity of each of these sanctions. Such procedures shall be designed so as to minimize the time between identification of deficiencies and imposition of these sanctions and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies.".

(b) EFFECTIVE DATE.—Except as otherwise specifically provided in subsections (e) and (f) of section 1891 of the Social Security Act (as added by subsection (a)), the amendment made by subsection (a) shall become effective on the first day of the 18th calendar month to begin after the date of the enactment of this Act.

SEC. 4024. REQUIREMENT THAT INDIVIDUAL BE CONFINED TO HOME.

(a) PART A.—Section 1814(a) of the Social Security Act (42 U.S.C. 1395f(a)) is amended by adding at the end the following: "For purposes of paragraph (2)(C), an individual shall be considered to be 'confined to his home' if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered 'confined to his home', the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort by the individual, and that absences of the individual from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment.".

(b) PART B.—Section 1835(a) of such Act (42 U.S.C. 1395n(a)) is amended by adding at the end the following: "For purposes of paragraph (2)(A), an individual shall be considered to be 'confined to his home' if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered 'confined to his home', the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort by the individual, and that absences of the individual from home are infrequent or of relatively short duration, or are attributable to the need to receive medical treatment.".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to items and services provided on or after January 1, 1988.

SEC. 4025. HOME HEALTH TOLL-FREE HOTLINE AND INVESTIGATIVE UNIT.

(a) IN GENERAL.—Section 1864(a) of the Social Security Act (42 U.S.C. 1395aa(a)) is amended by adding at the end the following:

"Any agreement under this subsection shall provide for the appropriate State or local agency to maintain a toll-free hotline (1) to collect, maintain, and continually update information on home health agencies located in the State or locality that are certified to participate in the program established under this title (which information shall include any significant deficiencies found with respect to patient care in the most recent certification survey conducted with respect to the agency, when that survey was completed, whether corrective actions have been taken or are planned, and the sanctions, if any, imposed under this title with respect to the agency) and (2) to receive complaints (and answer questions) with respect to home health agencies in the State or locality. Any such agreement shall provide for such agency to maintain a unit for investigating such complaints that possesses enforcement authority and has access to survey and certification reports, information gathered by any private accreditation agency pursuant to an agreement with the Secretary under section 1864, and consumer medical records (but only with the consent of the consumer or his or her legal representative).".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to agreements entered into or renewed on or after the date of enactment of this Act.

SEC. 4026. HOME HEALTH AGENCY COST LIMITS.

(a) DATA USED TO DETERMINE LIMITS.—

(1) Section 1861(v)(1)(L) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)) is amended by adding at the end the following new clause:

"(iii) In establishing limits under this subparagraph, the Secretary shall—

"(I) utilize a wage index that is based on audited wage data obtained from home health agencies, and

"(II) base such limits on the most recent audited wage data available, which data may be for cost reporting periods beginning no earlier than July 1, 1985.".

(2) The amendment made by paragraph (1) shall apply to cost reporting periods beginning on or after July 1, 1988.

(b) STUDY OF LIMITS.—The Secretary of Health and Human Services shall study and report to the Congress, not later than June 1, 1988, on—

(1) whether the separate schedules of cost limits currently applied to home health agencies under title XVIII of the Social Security Act located in urban and rural areas accurately reflect differences in the costs of urban and rural home health agencies, and

(2) the appropriateness of modifying such limits to take into account the proportion of agency patients who are from urban and rural areas.

SEC. 4027. HOME HEALTH PROSPECTIVE PAYMENT DEMONSTRATION PROJECT.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall provide for a demonstration project to develop and test alternative methods of paying home health agencies on a prospective basis for services furnished under the medicare and medicaid programs. The project

shall be designed in a manner to enable the Secretary to evaluate the effects of various methods of prospective payment (including payments on a per-visit, per-case, and per-episode basis) on program expenditures, access to, and quality of, home health care, and home health agency operations. The Secretary shall assure that services are first furnished under the project not later than July 1, 1988, and, for this purpose, the Secretary may reinstate a previously awarded contract, or award a sole source contract, to carry out the project.

(b) FUNDING.—The provisions of subsection (a)(2) and the first sentence of subsection (b) of section 402 of the Social Security Amendments of 1967 shall apply to the demonstration project under subsection (a) of this section as they apply to experiments under subsection (a)(1) of that section.

(c) REPORT.—The Secretary shall submit to Congress, not later than one year after the date of the enactment of this Act, an interim report on the demonstration project and, not later than four years after the date of the enactment of this Act, a final report on the results of the project.

Subpart C—Other Provisions

SEC. 4031. PAYMENT CYCLE STANDARDS.

(a) PAYMENT FLOOR STANDARDS.—

(1) Section 1816(c) of the Social Security Act (42 U.S.C. 1395h(c)) is amended by adding at the end the following new paragraph:

"(3)(A) Each agreement under this section shall provide that no payment shall be issued, mailed, or otherwise transmitted with respect to any claim submitted under this title within the applicable number of calendar days after the date on which the claim is received.

"(B) In this paragraph, the term 'applicable number of calendar days' means—

"(i) with respect to claims received in the 3-month period beginning July 1, 1988, 10 days, and

"(ii) with respect to claims received in the 12-month period beginning October 1, 1988, 14 days.

(2) Section 1842(c) of such Act (42 U.S.C. 1395u(c)) is amended by adding at the end the following new paragraph:

"(3)(A) Each contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall provide that no payment shall be issued, mailed, or otherwise transmitted with respect to any claim submitted under this title within the applicable number of calendar days after the date on which the claim is received.

"(B) In this paragraph, the term 'applicable number of calendar days' means—

"(i) with respect to claims received in the 3-month period beginning July 1, 1988, 10 days, and

"(ii) with respect to claims received in the 12-month period beginning October 1, 1988, 14 days.

(3)(A) The amendments made by paragraphs (1) and (2) shall apply to claims received on or after July 1, 1988.

(B) The Secretary of Health and Human Services shall provide for such timely amendments to agreements under section 1816 of the Social Security Act and contracts under section 1842 of such Act, and regulations, to such extent as may be necessary to implement the provisions of this subsection on a timely basis.

(b) PROHIBITION OF OTHER POLICIES INTENDED TO SLOW DOWN MEDICARE PAYMENTS.—Notwithstanding any other provision of law, except as specifically provided in this section, the Secretary of Health and Human Services is not authorized to issue, after the date of the enactment of this Act, and before October 1, 1990, any final regulation, instruction, or other policy change which is primarily intended to have the effect of slowing down claims processing, or delaying payment of claims, under title XVIII of the Social Security Act.

(c) BUDGET CONSIDERATIONS.—For purposes of section 202 of the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987, this section is a necessary (but secondary) result of a significant policy change.

SEC. 4032. DENIALS AND RECONSIDERATIONS OF CLAIMS FOR HOME HEALTH SERVICES, EXTENDED CARE SERVICES, AND POST-HOSPITAL EXTENDED CARE SERVICES.

(a) NOTIFICATION AND PHYSICIAN REVIEW.—Section 1816 of the Social Security Act (42 U.S.C. 1395h) is amended by adding at the end the following new subsection:

"(j) An agreement with an agency or organization under this section shall require that, with respect to a claim for home health services, extended care services, or post-hospital extended care services submitted by a provider to such agency or organization that is denied, such agency or organization—

"(1) furnish the provider and the individual with respect to whom the claim is made with a written explanation of the denial and of the statutory or regulatory basis for the denial; and

"(2) promptly notify such individual and the provider of disposition of such reconsideration.".

(b) PERFORMANCE STANDARDS FOR FISCAL INTERMEDIARIES AND CARRIERS.—Section 1816(f) of such Act (42 U.S.C. 1395h(f)) is amended by adding at the end the following: "Such standards and criteria shall include with respect to claims for services furnished under this part by any provider of services other than a hospital whether such agency or organization is able to process 75 percent of reconsiderations within 60 days (except in the case of the fiscal year 1989, 66 percent of reconsiderations) and 90 percent of reconsiderations within 90 days and the extent to which its determinations are reversed on appeal.".

(c) EFFECTIVE DATE.—

(1)(A) The amendment made by subsection (a) shall apply with respect to claims received on or after January 1, 1988.

(B) The amendment made by subsection (b) shall apply with respect to claims filed on or after October 1, 1988.

(2) The Secretary of Health and Human Services shall provide for such timely amendments to agreements under section

1816 and contracts under section 1842 of the Social Security Act, and regulations, to such extent as may be necessary to implement the amendments made by subsections (a) and (b) on a timely basis.

SEC. 4033. PERMITTING DISABLED INDIVIDUALS TO RENEW ENTITLEMENT TO MEDICARE AFTER GAINFUL EMPLOYMENT WITHOUT A 2-YEAR WAITING PERIOD.

(a) IN GENERAL.—

(1) Section 226(f) of the Social Security Act (42 U.S.C. 426(f)) is amended by inserting before the period at the end the following: ", unless the physical or mental impairment which is the basis for disability is the same as (or directly related to) the physical or mental impairment which served as the basis for disability in such previous period".

(2)(A) The amendment made by subsection (a) shall apply to months beginning after the end of the 60-day period beginning on the date of enactment of this Act.

(B) The amendment made by subsection (a) shall not apply so as to include (for the purposes described in section 226(f) of the Social Security Act) monthly benefits paid for any month in a previous period (described in that section) that terminated before the end of the 60-day period described in paragraph (1).

SEC. 4034. APPLICATION OF SECONDARY PAYER PROVISIONS TO GOVERNMENTAL ENTITIES.

(a) IN GENERAL.—Section 1862(b)(4)(B)(i) of the Social Security Act (42 U.S.C. 1395y(b)(4)(B)(i)), as added by the amendment made by section 9319(a) of the Omnibus Budget Reconciliation Act of 1986, is amended by striking "section 5000(b) of the Internal Revenue Code of 1986" and inserting "subsection (b) of section 5000 of the Internal Revenue Code of 1986 without regard to subsection (d) of such section".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall be effective as if included in the enactment of section 9319(a) of the Omnibus Budget Reconciliation Act of 1986.

SEC. 4035. PUBLICATION AND NOTIFICATION OF POLICIES.

(a) REQUIRING PUBLICATION OF INTERMEDIARY AND CARRIER BUDGET METHODOLOGY.—

(1) Section 1816(c)(1) of the Social Security Act (42 U.S.C. 1395h(c)(1)) is amended by adding at the end the following sentence: "The Secretary shall cause to have published in the Federal Register, by not later than September 1 before each fiscal year, data, standards, and methodology to be used to establish budgets for fiscal intermediaries under this section for that fiscal year, and shall cause to be published in the Federal Register for public comment, at least 90 days before such data, standards, and methodology are published, the data, standards, and methodology proposed to be used.".

(2) Section 1842(c)(1) of such Act (42 U.S.C. 1395u(c)(1)) is amended by adding at the end the following sentence: "The Secretary shall cause to have published in the Federal Register, by not later than September 1 before each fiscal year, data, standards, and methodology to be used to establish budgets for carriers under this section for that fiscal year, and shall cause to be

published in the Federal Register for public comment, at least 90 days before such data, standards, and methodology are published, the data, standards, and methodology proposed to be used.".

(3) The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to budgets for fiscal years beginning with fiscal year 1989.

(b) PUBLICATION AS REGULATIONS OF SIGNIFICANT POLICIES.—Section 1871(a) of such Act (42 U.S.C. 1395hh(a)) is amended—

(1) by inserting "(1)" after "(a)"; and

(2) by adding at the end the following new paragraph:

"(2) No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this title shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).".

(c) MISCELLANEOUS PUBLICATION AND INFORMATION ACCESS PROVISIONS.—Section 1871 of such Act (42 U.S.C. 1395hh) is amended by adding at the end the following new subsection:

"(c)(1) The Secretary shall publish in the Federal Register, not less frequently than every 3 months, a list of all manual instructions, interpretative rules, statements of policy, and guidelines of general applicability which—

"(A) are promulgated to carry out this title, but

"(B) are not published pursuant to subsection (a)(1) and have not been previously published in a list under this subsection.

"(2) Effective June 1, 1988, each fiscal intermediary and carrier administering claims for extended care, post-hospital extended care, home health care, and durable medical equipment benefits under this title shall make available to the public all interpretative materials, guidelines, and clarifications of policies which relate to payments for such benefits.

"(3) The Secretary shall to the extent feasible make such changes in automated data collection and retrieval by the Secretary and fiscal intermediaries with agreements under section 1816 as are necessary to make easily accessible for the Secretary and other appropriate parties a data base which fairly and accurately reflects the provision of extended care, post-hospital extended care and home health care benefits pursuant to this title, including such categories as benefit denials, results of appeals, and other relevant factors, and selectable by such categories and by fiscal intermediary, service provider, and region.".

SEC. 4036. END-STAGE RENAL DISEASE AMENDMENTS.

(a) IMPLEMENTATION OF PRIMARY PAYER REQUIREMENTS FOR END-STAGE RENAL DISEASE PROGRAM.—

(1) Section 1862(b)(2)(A) of the Social Security Act (42 U.S.C. 1395y(b)(2)(A)) is amended by striking "(ii)" and all that follows through "under this title" and inserting "(ii) can reasonably be expected to be made under such a plan".

(2) The amendment made by paragraph (1) shall apply with respect to items and services furnished on or after 30 days after the date of the enactment of this Act.

(b) LIMITATION OF MINIMUM UTILIZATION RATE REQUIREMENT FOR END-STAGE RENAL DISEASE TRANSPLANTATIONS.—The last sentence of section 1881(b)(1) of such Act (42 U.S.C. 1395rr(b)(1)) is amended by striking "covered procedures and for self-dialysis training programs" and inserting "transplantations".

(c) EXTENSION OF DEADLINE FOR ESTABLISHING PROTOCOLS ON REUSE OF DIALYSIS FILTERS AND OTHER DIALYSIS SUPPLIES AS IT RELATES TO THE REUSE OF BLOODLINES.—

(1)(A) Section 9335(k)(2) of the Omnibus Budget Reconciliation Act of 1986 is amended by inserting "(or July 1, 1988, with respect to protocols that relate to the reuse of bloodlines)" after "October 1, 1987".

(B) The amendment made by subparagraph (A) shall be effective as if included in the enactment of section 9335(k)(2) of the Omnibus Budget Reconciliation Act of 1986.

(2) Section 1881(f)(7)(B) of the Social Security Act (42 U.S.C. 1395rr(f)(7)(B)) is amended by inserting "(or July 1, 1988, with respect to protocols that relate to the reuse of bloodlines)" after "January 1, 1988".

(d) STUDIES OF END-STAGE RENAL DISEASE PROGRAM.—

(1) The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall arrange for a study of the end-stage renal disease program within the medicare program.

(2) Among other items, the study shall address—

(A) access to treatment by both individuals eligible for medicare benefits and those not eligible for such benefits;

(B) the quality of care provided to end-stage renal disease beneficiaries, as measured by clinical indicators, functional status of patients, and patient satisfaction;

(C) the effect of reimbursement on quality of treatment;

(D) major epidemiological and demographic changes in the end-stage renal disease population that may affect access to treatment, the quality of care, or the resource requirements of the program; and

(E) the adequacy of existing data systems to monitor these matters on a continuing basis.

(3) The Secretary shall submit to Congress, not later than 3 years after the date of the enactment of this Act, a report on the study.

(4) The Secretary shall request the National Academy of Sciences, acting through the Institute of Medicine, to submit an application to conduct the study described in this section. If the Academy submits an acceptable application, the Secretary shall enter into an appropriate arrangement with the Academy for the conduct of the study. If the Academy does not submit an acceptable application to conduct the study, the Secretary may request one or more appropriate nonprofit private entities to submit an application to conduct the study and may enter into an appropriate arrangement for the conduct of the study by the entity which submits the best acceptable application.

(5) Section 1881 of the Social Security Act (42 U.S.C. 1395rr) is amended—

(A) in subsection (c)(2)(F), by striking "and subsection (g)",

(B) by striking the last sentence of subsection (c)(6),

(C) by striking subsection (g), and

(D) by redesignating subsection (h), as added by section 20 of the Medicare and Medicaid Patient and Program Protection Act of 1987 (Public Law 100-93), as subsection (g).

SEC. 4037. MEDICARE HEARINGS AND APPEALS.

(a) MAINTAINING CURRENT SYSTEM FOR HEARINGS AND APPEALS.—Any hearing conducted under section 1869(b)(1) of the Social Security Act prior to the earliest of the date on which the Secretary of Health and Human Services submits the report required to be submitted by the Secretary under subsection (b)(1) or September 1 shall be conducted by Administrative Law Judges of the Office of Hearings and Appeals of the Social Security Administration in the same manner as are hearings conducted under section 205(b)(1) of such Act.

(b) STUDY AND REPORT ON USE OF TELEPHONE HEARINGS.—

(1) The Secretary of Health and Human Services and the Comptroller General of the United States shall each conduct a study on holding hearings under section 1869(b)(1) of the Social Security Act by telephone and shall each report the results of the study not later than 6 months after the date of enactment of this Act.

(2) The studies under paragraph (1) shall focus on whether telephone hearings allow for a full and fair evidentiary hearing, in general, or with respect to any particular category of claims and shall examine the possible improvements to the hearing process (such as cost-effectiveness, convenience to the claimant, and reduction in time under the process) resulting from the use of such hearings as compared to the adoption of other changes to the process (such as expansions in staff and resources).

SEC. 4038. RURAL HEALTH MEDICAL EDUCATION DEMONSTRATION PROJECT.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall enter into agreements with four sponsoring hospitals submitting applications under this subsection to conduct demonstration projects to assist resident physicians in developing field clinical experience in rural areas.

(b) NATURE OF PROJECT.—Under a demonstration project conducted under subsection (a), a sponsoring hospital entering into an agreement with the Secretary under such subsection shall enter into arrangements with a small rural hospital to provide to such rural hospital, for a period of one to three months of training, physicians (in such number as the agreement under subsection (a) may provide) who have completed one year of residency training.

(c) SELECTION.—In selecting from among applications submitted under subsection (a), the Secretary shall ensure that four small rural hospitals located in different counties participate in the demonstration project and that—

(1) two of such hospitals are located in rural counties of more than 2,700 square miles (one of which is east of the Mississippi River and one of which is west of such river); and

(2) two of such hospitals are located in rural counties with (as determined by the Secretary) a severe shortage of physicians (one of which is east of the Mississippi River and one of which is west of such river).

(d) CLARIFICATION OF PAYMENT.—For purposes of section 1886 of the Social Security Act—

(1) with respect to subsection (d)(5)(B) of such section, any resident physician participating in the project under subsection (a) for any part of a year shall be treated as if he or she were working at the appropriate sponsoring hospital with an agreement under subsection (a) on September 1 of such year (and shall not be treated as if working at the small rural hospital); and

(2) with respect to subsection (h) of such section, the payment amount permitted under such subsection for a sponsoring hospital with an agreement under subsection (a) shall be increased (for the duration of the project only) by an amount equal to the amount of any direct graduate medical education costs (as defined in paragraph (5) of such subsection (h)) incurred by such hospital in supervising the education and training activities under a project under subsection (a).

(e) DURATION OF PROJECT.—Each demonstration project under subsection (a) shall be commenced not later than six months after the date of enactment of this Act and shall be conducted for a period of three years.

(f) DEFINITION.—In this section, the term "sponsoring hospital" means a hospital that receives payments under sections 1886(d)(5)(B) and 1886(h) of the Social Security Act.

SEC. 4039. MISCELLANEOUS AND TECHNICAL PROVISIONS.

(a) CLARIFICATION OF CRIMINAL PENALTIES FOR WILLFUL MISREPRESENTATIONS.—Subsection (c) of section 1128B of the Social Security Act (42 U.S.C. 1320a–7b)), as redesignated by section 4(d) of the Medicare and Medicaid Patient and Program Protection Act of 1987 (Public Law 100–93), is amended—

(1) by striking "institution or facility" each place it appears and inserting "institution, facility, or entity", and

(2) by inserting "(including an eligible organization under section 1876(b))" after "other entity".

(b) PODIATRISTS.—

(1) Section 1861(r)(3) of the Social Security Act (42 U.S.C. 1395x(r)(3)) is amended—

(A) by striking "subsection (s) of this section" and inserting "subsections (k), (m), (p)(1), and (s) of this section and sections 1814(a), 1832(a)(2)(F)(ii), and 1835", and

(B) by striking "; and for the purposes" and all that follows through "which he is legally authorized to perform".

(2) Section 1861(b)(6) of such Act (42 U.S.C. 1395x(b)(6)) is amended by striking "Council on Podiatry Education of the American Podiatry Association" and inserting "Council on Podiatric Medical Education of the American Podiatric Medical Association".

(c) RECOVERY OF PAYMENTS FOR CERTAIN PACEMAKER DEVICES.—

(1) Section 1862(h) of such Act (42 U.S.C. 1395y(h)) is amended—

(A) in paragraph (1)(B), by striking "law," and inserting "law (and any amount paid to a provider under any such warranty),";

(B) in paragraph (1)(D), by striking "(3)," and inserting "(3), in determining the amount subject to repayment under paragraph (2)(C),";

(C) in paragraph (2)—

(i) by striking "and" at the end of subparagraph (A),

(ii) by striking the period at the end of subparagraph (B) and inserting ", and", and

(iii) by adding at the end the following new subparagraph:

"(C) to make repayment to the Secretary of amounts paid under this title to the provider with respect to any cardiac pacemaker device or lead which has been replaced by the manufacturer, or for which the manufacturer has made payment to the provider, under an express or implied warranty."; and

(D) in paragraph (4)(B)—

(i) by striking "or has" and inserting ", has", and

(ii) by striking "(2)(B)," and inserting "(2)(B), or has failed to make repayment to the Secretary as required under paragraph (2)(C),".

(2) The amendments made by paragraph (1) shall become effective on January 1, 1988.

(d) EXTEND AND CLARIFY PROHIBITION ON COST SAVINGS POLICIES BEFORE BEGINNING OF FISCAL YEAR.—Notwithstanding any other provision of law, except as required to implement specific provisions required under statute, the Secretary of Health and Human Services is not authorized to issue in final form, after the date of the enactment of this Act and before October 15, 1988, any regulation, instruction, or other policy which is estimated by the Secretary to result in a net reduction in expenditures under title XVIII of the Social Security Act in fiscal year 1989 of more than $50,000,000.

(e) MORATORIUM ON PRIOR AUTHORIZATION FOR HOME HEALTH AND POST-HOSPITAL EXTENDED CARE SERVICES.—The Secretary of Health and Human Services shall not implement any voluntary or mandatory program of prior authorization for home health services, extended care services, or post-hospital extended care services under part A or B of title XVIII of the Social Security Act at any time prior to six months after the date on which the Congress receives the report required under section 9305(k)(4) of the Omnibus Budget Reconciliation Act of 1986.

(f) DELAY IN PUBLISHING REGULATIONS WITH RESPECT TO DEEMING THE STATUS OF ENTITIES.—The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall not deem any entity to be a provider of services (as defined in section 1861(u) of the Social Security Act) for purposes of title XVIII of such Act—

(1) on any date prior to 6 months after the date on which the Secretary has published a proposed rule with respect to the deeming of the entity, and

(2) until the Secretary publishes a final rule with respect to the deeming of the entity.

(g) USE OF INTERIM FINAL REGULATIONS.—The Secretary of Health and Human Services shall issue such regulations (on an interim or other basis) as may be necessary to implement this subtitle and the amendments made by this subtitle.

PART 3—RELATING TO PART B

Subpart A—Provisions Relating to Payments for Physicians' Services

SEC. 4041. FREEZE IN PAYMENTS FOR PHYSICIANS' SERVICES; EXTENSION OF SEQUESTER ORDER.

(a) THREE-MONTH FREEZE ON INCREASES IN PHYSICIAN PAYMENTS.—

(1) IN GENERAL.—Section 1842 of the Social Security Act (42 U.S.C. 1395u) is amended—

(A) in subsection (b)(4)—

(i) in subparagraph (A), by redesignating clause (v) as clause (vi) and by inserting after clause (iv) the following new clause:

"(v) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services furnished during the 3-month period beginning January 1, 1988, the Secretary shall not set any level higher than the same level as was set for the 12-month period beginning January 1, 1987.", and

(ii) in subparagraph (B), by adding at the end the following new clause:

"(iii) In determining the reasonable charge under paragraph (3) for physicians' services furnished during the 3-month period beginning January 1, 1988, the customary charges shall be the same customary charges as were recognized under this section for the 12-month period beginning January 1, 1987."; and

(B) in subsection (j)(1)(C), by adding at the end thereof the following new clause:

"(vii) Notwithstanding any other provision of this subparagraph, the maximum allowable actual charge for a particular physicians' service furnished by a nonparticipating physician to individuals enrolled under this part during the 3-month period beginning on January 1, 1988, shall be the amount determined under this subparagraph for 1987. The maximum allowable actual charge for any such service otherwise determined under this subparagraph for 1988 shall take effect on April 1, 1988.".

(2) EXTENSION OF PHYSICIAN PARTICIPATION AGREEMENTS AND RELATED PROVISIONS.—Notwithstanding any other provision of law—

(A) subject to the last sentence of this paragraph, each agreement with a participating physician in effect on December 31, 1987, under section 1842(h)(1) of the Social Security Act shall remain in effect for the three-month period beginning on January 1, 1988;

(B) the effective period for agreements under such section entered into for 1988 shall be the nine-month period beginning on April 1, 1988, and the Secretary shall provide an opportunity for physicians to enroll as participating physicians prior to April 1, 1988;

(C) instead of publishing, under section 1842(h)(4) of the Social Security Act at the beginning of 1988, directories of participating physicians for 1988, the Secretary shall provide for such publication, at the beginning of the 9-month period beginning on April 1, 1988, of such directories of participating physicians for such period; and

(D) instead of providing to nonparticipating physicians, under section 1842(b)(3)(G) of the Social Security Act at the beginning of 1988, a list of maximum allowable actual charges for 1988, the Secretary shall provide, at the beginning of the 9-month period beginning on April 1, 1988, to such physicians such a list for such 9-month period.

An agreement with a participating physician in effect on December 31, 1987, under section 1842(h)(1) of the Social Security Act shall not remain in effect for the period described in subparagraph (A) if the participating physician requests on or before December 31, 1987, that the agreement be terminated.

(3)(A) Section 1842 of the Social Security Act (42 U.S.C. 1395u) is amended—

(i) in subsection (b)(2), by adding at the end the following: "In establishing such standards and criteria, the Secretary shall provide a system to measure a carrier's performance of responsibilities described in paragraph (3)(H) and subsection (h).''; and

(ii) in subsection (c)(1), by inserting "(A)" after "(c)(1)" and by adding at the end the following new subparagraph:

"(B) Of the amounts appropriated for administrative activities to carry out this part, the Secretary shall provide payments, totaling 1 percent of the total payments to carriers for claims processing in any fiscal year, to carriers under this section, to reward carriers for their success in increasing the proportion of physicians in the carrier's service area who are participating physicians or in increasing the proportion of total payments for physicians' services which are payments for such services rendered by participating physicians.''.

(B) Section 9332(a) of the Omnibus Budget Reconciliation Act of 1986 is amended—

(i) by striking paragraphs (2) and (3),

(ii) in paragraph (4)(B), by striking "under paragraph (2)" and inserting "under the last sentence of section 1842(b)(2) of the Social Security Act", and

(iii) in paragraph (4)(C)—

(I) by striking "under paragraph (3)" and inserting "under section 1842(c)(1)(B) of the Social Security Act",

(II) by striking "April" and inserting "July", and

(III) by striking "at the end of 1987" and inserting "before April 1, 1988".

(b) EXTENSION OF REDUCTION UNDER SEQUESTER ORDER.—Notwithstanding any other provision of law (including any other provision of this Act), the reductions in the amount of payments required

under title XVIII of the Social Security Act made by the final sequester order issued by the President on November 20, 1987, pursuant to section 252(b) of the Balanced Budget Emergency Deficit Control Act of 1985 shall continue to be effective (as provided by sections 252(a)(4)(B) and 256(d)(2) of such Act) through March 31, 1988, with respect to payments for physicians' services under part B of such title.

SEC. 4042. GENERAL UPDATE IN PAYMENTS FOR PHYSICIANS' SERVICES.

(a) INCREASE IN MEI FOR 1988 AND 1989.—Section 1842(b)(4) of the Social Security Act (42 U.S.C. 1395u(b)(4)) is amended by adding at the end the following new subparagraph:

"(F)(i) For purposes of this part for physicians' services furnished in 1987, the percentage increase in the MEI is 3.2 percent.

"(ii) For purposes of this part for physicians' services furnished in 1988, on or after April 1, the percentage increase in the MEI is—

"(I) 3.6 percent for primary care services (as defined in subparagraph (E)(iii)), and

"(II) 1 percent for other physicians' services.

"(iii) For purposes of this part for physicians' services furnished in 1989, the percentage increase in the MEI is—

"(I) 3.0 percent for primary care services; and

"(II) 1 percent for other physician's services.".

(b) PRIMARY CARE SERVICES DEFINED.—Section 1842(b)(4)(E) of such Act (42 U.S.C. 1395u(b)(4)(E)) is amended by adding at the end thereof the following new clause:

"(iii) The term 'primary care services' means physicians' services which constitute office medical services, emergency department services, home medical services, skilled nursing, intermediate care, and long-term care medical services, or nursing home, boarding home, domiciliary, or custodial care medical services.".

(c) PARTICIPATING PHYSICIAN DIFFERENTIAL.—Section 1842(b)(4)(A)(iv) of such Act (42 U.S.C. 1395u(b)(4)(A)(iv)) is amended—

(1) by striking "96 percent" and inserting "applicable percent", and

(2) by adding at the end the following: "In the previous sentence, the term 'applicable percent' means for services furnished (I) on or after January 1, 1987, and before April 1, 1988, 96 percent, (II) on or after April 1, 1988, and before January 1, 1988, 95.5 percent, and (III) on or after January 1, 1989, 95 percent.".

SEC. 4043. INCENTIVE PAYMENTS FOR PHYSICIANS' SERVICES FURNISHED IN UNDERSERVED AREAS.

(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

"(m) In the case of physicians' services furnished to an individual, who is covered under the insurance program established by this part and who incurs expenses for such services, in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act) as a class 1 or class 2 health manpower shortage area, in addition to the amount otherwise paid under this part, there also shall be paid to the physician (or to an employer or facility in the cases

described in clause (A) of section 1842(b)(6)) (on a monthly or quarterly basis) from the Federal Supplementary Medical Insurance Trust Fund an amount equal to 5 percent of the payment amount for the service under this part.".

(b) STUDY.—The Secretary of Health and Human Services shall study and report to Congress, by not later than January 1, 1990, on the feasibility of making additional payments described in section 1833(m) of the Social Security Act with respect to physician services which are performed in health manpower shortage areas located in urban areas.

(c) EFFECTIVE DATE.—The amendments made by this subsection (a) shall apply with respect to services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act)) on or after January 1, 1989, and to other services furnished on or after January 1, 1991.

SEC. 4044. ADJUSTMENT IN PREVAILING CHARGE LEVEL FOR PRIMARY CARE SERVICES.

(a) INCREASE IN PREVAILING CHARGES FOR PRIMARY CARE SERVICES.—Section 1842(b)(4)(A) of the Social Security Act (42 U.S.C. 1395u(b)(4)(A)), as amended by section 4041(a)(1) of this subtitle, is further amended by redesignating clause (vi) as clause (vii) and by inserting after clause (v) the following new clause:

"(vi) Before each year (beginning with 1989), the Secretary shall establish a prevailing charge floor for primary care services (as defined in subparagraph (E)(iii)) equal to 50 percent of the average of the prevailing charge levels (determined, for participating physicians under the third and fourth sentences of paragraph (3) and under paragraph (4), without regard to this clause and without regard to physician specialty) for such service for all localities in the United States (weighted by the relative frequency of the service in each locality) for the year.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payment for physicians' services furnished on or after January 1, 1989.

SEC. 4045. REDUCTION IN PREVAILING CHARGE LEVEL FOR OVERPRICED PROCEDURES.

(a) IN GENERAL.—Paragraph (10) of section 1842(b) of the Social Security Act (42 U.S.C. 1395u(b)) is amended to read as follows:

"(10)(A)(i) In determining the reasonable charge under paragraph (3) for procedures described in subparagraph (C) and performed during the 9-month period beginning on April 1, 1988, the prevailing charge for such procedure for participating and nonparticipating physicians shall be the prevailing charge otherwise recognized for such procedure for 1987—

"(I) subject to clause (iii), reduced by 2.0 percent, and

"(II) further reduced by the applicable percentage specified in clause (ii).

"(ii) For purposes of clause (i), the applicable percentage specified in this clause is—

"(I) 15 percent, in the case of a prevailing charge otherwise recognized (without regard to this paragraph and determined without regard to physician specialty) that is at least 150 percent of the weighted national average (as determined by the Sec-

retary) of such prevailing charges for such procedure for all localities in the United States for 1987;

"(II) 0 percent, in the case of a prevailing charge that does not exceed 85 percent of such weighted national average; and

"(III) in the case of any other prevailing charge, a percent determined on the basis of a straight-line sliding scale, equal to $^{3}/_{13}$ of a percentage point for each percent by which the prevailing charge exceeds 85 percent of such weighted national average.

"(iii) In no case shall the reduction under clause (i) for a procedure result in a prevailing charge in a locality for 1988 which is less than 85 percent of the Secretary's estimate of the weighted national average of such prevailing charges for such procedure for all localities in the United States for 1987 (based upon the best available data and determined without regard to physician specialty) after making the reduction described in clause (i)(II).

"(B) The procedures described in this subparagraph are as follows: bronchoscopy, carpal tunnel repair, cataract surgery, coronary artery bypass surgery, diagnostic and/or therapeutic dilation and curettage, knee arthroscopy, knee arthroplasty, pacemaker implantation surgery, total hip replacement, suprapubic prostatectomy, transurethral resection of the prostate, and upper gastrointestinal endoscopy.

"(C) In the case of a reduction in the reasonable charge for a physicians' service under subparagraph (A), if a nonparticipating physician furnishes the service to an individual entitled to benefits under this part, after the effective date of such reduction, the physician's actual charge is subject to a limit under subsection (j)(1)(D).

"(D) There shall be no administrative or judicial review section 1869 or otherwise of any determination under subparagraph (A) or under paragraph (11)(B)(ii).".

(b) MODIFICATION OF GEOGRAPHIC INDEX.—Section 1845(e)(4)(A)(i) of such Act (42 U.S.C. 1395w-1(e)(4)(A)(i)) is amended by inserting "and costs of living" after "costs of practice".

(c) CONSOLIDATED CHARGE LIMITATION PROVISIONS.—

(1) PENALTIES FOR EXCESS CHARGES.—Section 1842 of such Act is further amended—

(A) in subsection (b)(11)(C)—

(i) in clause (i), by striking "(subject to clause (iv))" and all that follows through the end and inserting the following: ", the physician's actual charge is subject to a limit under subsection (j)(1)(D).";

(ii) in clause (i), by striking "(i)" after "(C)"; and

(iii) by striking clauses (ii) through (iv); and

(B) in subsection (j)(1), by adding at the end the following new subparagraph:

"(D)(i) If an action described in clause (ii) results in a reduction in a reasonable charge for a physicians' service or item and a nonparticipating physician furnishes the service or item to an individual entitled to benefits under this part after the effective date of such action, the physician may not charge the individual more than 125 percent of the reduced payment allowance (as defined in clause (iii)) plus (for services or items furnished during the 12-month period (or 9-month period in the case of an action described in

clause (ii)(II)) beginning on the effective date of the action) ½ of the amount by which the physician's maximum allowable actual charge for the service or item for the previous 12-month period exceeds such 125 percent level.

"(ii) The first sentence of clause (i) shall apply to—

"(I) an adjustment under subsection (b)(8)(B) (relating to inherent reasonableness),

"(II) a reduction under subsection (b)(10)(A) (relating to certain overpriced procedures),

"(III) a reduction under subsection (b)(11)(B) (relating to certain cataract procedures), and

"(IV) an adjustment under section 1833(l)(3)(B) (relating to physician supervision of certified registered nurse anesthetists).

"(iii) In clause (i), the term 'reduced payment allowance' means, with respect to an action—

"(I) under subsection (b)(8)(B), the inherently reasonable charge established under subsection (b)(8); or

"(II) under subsection (b)(10)(A) or (b)(11)(B) or under section 1833(l)(3)(B), the prevailing charge for the service after the action.

"(iv) If a physician knowingly and willfully imposes a charge in violation of clause (i) (whether or not such charge violates subparagraph (B)), the Secretary may apply sanctions against such physician in accordance with paragraph (2).

"(v) Clause (i) shall not apply to items and services furnished after the earlier of (I) December 31, 1990, or (II) one-year after the date the Secretary reports to Congress, under section 1845(e)(3), on the development of the relative value scale under section 1845.".

(2) CONFORMING AMENDMENTS.—(A) Section 1833(l)(6) of such Act (42 U.S.C. 1395l(l)(6)) is amended—

(i) in subparagraph (A), by striking "(subject to subparagraph (D))" and all that follows through the end and inserting the following: "after the effective date of the reduction, the physician's actual charge is subject to a limit under section 1842(j)(1)(D).";

(ii) in subparagraph (A), by striking "(A)" after "(6)"; and

(iii) by striking subparagraphs (B) through (D).

(B) Section 1842(b)(11)(B)(i) of such Act (42 U.S.C. 1395u(b)(11)(B)(i)) is amended by striking "and shall be further reduced" and all that follows through "1988".

(C) Section 9334(b)(2) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking "1842(b)(10)" and inserting "1842(j)(1)(D)".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after April 1, 1988, except the amendment made by subsection (c)(2)(B) shall apply to services furnished on or after January 1, 1988.

SEC. 4046. LIMITS ON PAYMENT FOR OPHTHALMIC ULTRASOUND.

(a) IN GENERAL.—Section 1842 of the Social Security Act (42 U.S.C. 1395u), as previously amended by this subpart is amended—

(1) in subsection (b)(11)—

(A) in subparagraph (C), as redesignated under section 4045(c)(1)(A)(ii) of this title, by inserting "or (C)" after "subparagraph (B)";

(B) by redesignating subparagraph (C) as subparagraph (D); and

(C) by inserting after subparagraph (B) the following new subparagraph:

"(C) The prevailing charge level determined with respect to A-mode ophthalmic ultrasound procedures may not exceed 5 percent of the prevailing charge level established with respect to extracapsular cataract removal with lens implantation."; and

(2) in subparagraph (D) of subsection (j)(1), as added by section 4045(c)(1)(B) of this subtitle—

(A) in clause (ii), by striking "and" at the end of subclause (III), by redesignating subclause (IV) as subclause (V) and by inserting before such subclause the following new subclause:

"(IV) a prevailing charge limit is established under subsection (b)(11)(C)(i), and"; and

(B) in clause (iii)(II), by striking "or (b)(11)(B)" and inserting ", (b)(11)(B), or (b)(11)(C)(i)".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to services furnished on or after April 1, 1988.

SEC. 4047. CUSTOMARY CHARGES FOR PRIMARY CARE SERVICES OF NEW PHYSICIANS.

(a) IN GENERAL.—Section 1842(b)(4) of the Social Security Act, as amended by section 4042(a), is further amended by adding at the end thereof the following new subparagraph:

"(G) In determining the customary charges for physicians' services (other primary care services and other than services furnished in a rural area (as defined in section 1886(d)(2)(D)) that is designated, under section 332(a)(1)(A) of the Public Health Service Act, as a health manpower shortage area) for which adequate actual charge data are not available because a physician has not yet been in practice for a sufficient period of time, the Secretary shall set a customary charge at a level no higher than 80 percent of the prevailing charge (as determined under the third and fourth sentences of paragraph (3) and under paragraph (4)) for a service.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to physicians who first furnish services to medicare beneficiaries after April 1, 1988.

SEC. 4048. PAYMENT FOR PHYSICIAN ANESTHESIA SERVICES.

(a) IN GENERAL.—Section 1842(b) of the Social Security Act (42 U.S.C. 1395u(b)) is further amended by adding at the end the following new paragraph:

"(14)(A) In determining the reasonable charge under paragraph (3) of a physician for medical direction of two or more nurse anesthetists performing, on or after April 1, 1988, and before January 1, 1991, anesthesia services in whole or in part concurrently, the number of base units which may be recognized with respect to such medical direction for each concurrent procedure (other than cataract surgery or an iridectomy) shall be reduced by—

"(i) 10 percent, in the case of medical direction of 2 nurse anesthetists concurrently,

"(ii) 25 percent, in the case of medical direction of 3 nurse anesthetists concurrently, and

"(iii) 40 percent, in the case of medical direction of 4 nurse anesthetists concurrently.

"(B) In determining the reasonable charge under paragraph (3) of a physician for medical direction of two or more nurse anesthetists performing, on or after January 1, 1989, and before January 1, 1991, anesthesia services in whole or in part concurrently, the number of base units which may be recognized with respect to such medical direction for each concurrent cataract surgery or iridectomy procedure shall be reduced by 10 percent.

"(C) The Secretary shall require claims for physicians' services for medical direction of nurse anesthetists during the periods in which the provisions of subparagraph (A) or (B) apply to indicate the number of such anesthetists being medically directed concurrently at any time during the procedure, the name of each nurse anesthetist being directed, and the type of procedure for which the services are provided.".

(b) DEVELOPMENT OF UNIFORM RELATIVE VALUE GUIDE.—The Secretary of Health and Human Services, in consultation with groups representing physicians who furnish anesthesia services, shall establish by regulation a relative value guide for use in all carrier localities in making payment for physician anesthesia services furnished under part B of title XVIII of the Social Security Act on and after January 1, 1989. Such guide shall be designed so as to result in expenditures under such title for such services in an amount that would not exceed the amount of such expenditures which would otherwise occur.

(c) STUDY OF PREVAILING CHARGES FOR ANESTHESIA SERVICES.—The Secretary of Health and Human Services shall conduct a study of the variations in conversion factors used by carriers under section 1842(b) of the Social Security Act to determine the prevailing charge for anesthesia services and shall report the results of the study and make recommendations for appropriate adjustments in such factors not later than January 1, 1989.

(d) GAO STUDIES.—(1) The Comptroller General shall conduct a study—

(A) to determine the average anesthesia times reported for medicare reimbursement purposes,

(B) to verify those times from patient medical records,

(C) to compare anesthesia times to average surgical times, and

(D) to determine whether the current payments for physician supervision of nurse anesthetists are excessive.

The Comptroller General shall report to Congress, by not later than January 1, 1989, on such study and in the report include recommendations regarding the appropriateness of the anesthesia times recognized by medicare for reimbursement purposes and recommendations regarding adjustments of payments for physician supervision of nurse anesthetists.

(2) The Comptroller General shall conduct a study on the impact of the amendment made by subsection (a), and shall report to Congress on the results of such study by April 1, 1990.

SEC. 4049. FEE SCHEDULES FOR RADIOLOGIST SERVICES.

(a) IN GENERAL.—Part B of title XVIII of the Social Security Act is amended—

(1) in section 1833(a)(1) (42 U.S.C. 1395l(a)(1)), as amended by section 4062(c)(3) of this subtitle by striking "and" before "(I)", and by adding at the end the following new clause: "and (J) with respect to expenses incurred for radiologist services (as defined in section 1834(b)(5)), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount provided under the fee schedule established under section 1834(b),"; and

(2) by adding at the end of section 1834, as subsequently inserted by section 4062(a) of this subtitle, the following new subsection:

"(b) FEE SCHEDULES FOR RADIOLOGIST SERVICES.—

"(1) DEVELOPMENT.—The Secretary shall develop—

"(A) a relative value scale to serve as the basis for the payment for radiologist services under this part, and

"(B) using such scale and appropriate conversion factors, fee schedules (on a regional, statewide, or carrier service area basis) for payment for radiologist services under this part, to be implemented for such services furnished during 1989.

"(2) CONSULTATION.—In carrying out paragraph (1), the Secretary shall regularly consult closely with the Physician Payment Review Commission, the American College of Radiology, and other organizations representing physicians or suppliers who furnish radiologist services and shall share with them the data and data analysis being used to make the determinations under paragraph (1), including data on variations in current medicare payments by geographic area, and by service and physician specialty.

"(3) CONSIDERATIONS.—In developing the relative value scale and fee schedules under paragraph (1), the Secretary—

"(A) shall take into consideration variations in the cost of furnishing such services among geographic areas and among different sites where services are furnished, and

"(B) may also take into consideration such other factors respecting the manner in which physicians in different specialties furnish such services as may be appropriate to assure that payment amounts are equitable and designed to promote effective and efficient provision of radiologist services by physicians in the different specialties.

"(4) SAVINGS.—

"(A) BUDGET NEUTRAL FEE SCHEDULES.—The Secretary shall develop preliminary fee schedules for 1989, which are designed to result in the same amount of aggregate payments (net of any insurance and deductibles under section 1835(a)(1)(I) and 1833(b)) for radiologist services furnished in 1989 as would have been made if this subsection had not been enacted.

"(B) INITIAL SAVINGS.—The fee schedules established for payment purposes under this subsection for services furnished in 1989 shall be 97 percent of the amounts permited

under this preliminary fee schedules developed under subparagraph (A).

"(C) SUBSEQUENT UPDATING.—Radiologist services furnished in subsequent years, the fee schedules shall be the schedules for the previous year updated by the percentage increase in the MEI (as defined in section 1842(b)(4)(E)(ii)) for the year.

"(C) NONPARTICIPATING PHYSICIANS.—Each fee schedule so established shall provide that the payment rate recognized for nonparticipating physicians and suppliers is equal to the appropriate percent (as defined in section 1842(b)(4)(A)(iv)) of the payment rate recognized for participating physicians and suppliers.

"(5) LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS.—

"(A) IN GENERAL.—In the case of radiologist services furnished after January 1, 1989, for which payment is made under a fee schedule under this subsection, if a nonparticipating physician or supplier furnishes the service to an individual entitled to benefits under this part, the physician or supplier may not charge the individual more than the limiting charge (as defined in subparagraph (B)).

"(B) LIMITING CHARGE DEFINED.—In subparagraph (A), the term 'limiting charge' means, with respect to a service furnished—

"(i) in 1989, 125 percent of the amount specified for the service in the appropriate fee schedule established under paragraph (1),

"(ii) in 1990, 120 percent of the amount specified for the service in the appropriate fee schedule established under paragraph (1), and

"(iii) after 1990, 115 percent of the amount specified for the service in the appropriate fee schedule established under paragraph (1).

"(C) ENFORCEMENT.—If a physician or supplier knowingly and willfully imposes a charge in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2).

"(5) RADIOLOGIST SERVICES DEFINED.—For the purposes of this subsection, section 1833(a)(1)(I), and section 1842(h)(1)(B), the term 'radiologist services' only includes radiologic services performed by, or under the direction or supervision of, a physician—

"(A) who is certified, or eligible to be certified, by the American Board of Radiology, or

"(B) for whom radiologic services account for at least 50 percent of billings made under this part.".

(b) DEADLINES AND EFFECTIVE DATE.—

(1) The Secretary of Health and Human Services shall establish the relative value scale and fee schedules for radiologist services (under section 1834(b) of the Social Security Act) by not later than August 1, 1988, and shall report to Congress on the development of such fee schedules not later than August 1, 1988.

(2) The amendments made by this section shall apply to services performed on or after January 1, 1989, and until such time as the Secretary of Health and Human Services implements physician fee schedules based on the relative value scale developed under section 1845(e) of the Social Security Act.

SEC. 4050. FEE SCHEDULES FOR PHYSICIAN PATHOLOGY SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall develop—

(1) a relative value scale to serve as the basis for the payment for physician pathology services under part B of title XVIII of the Social Security Act,

(2) using such scale and appropriate conversion factors, proposed fee schedules (on a regional, statewide, or carrier service area basis) for payment for physician pathology services under such part, that could be implemented for such services furnished during 1990, and

(3) an appropriate index to be applied to updating such fee schedules annually for physician pathology services furnished in years after 1990.

(b) CONSULTATION.—In carrying out subsection (a), the Secretary shall regularly consult closely with the Physician Payment Review Commission, the College of American Pathologists, and other organizations representing physicians who furnish physician pathology services and shall share with them the data and data analysis being used to make the determinations under subsection (a), including data on variations in current medicare payments by geographic area, and by service and physician specialty.

(c) CONSIDERATION.—In developing the fee schedules under subsection (a), the Secretary shall take into consideration variations in the cost of furnishing physician pathology services among geographic areas.

(d) REPORT.—The Secretary shall report, not later than April 1, 1989, to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate on the relative value scale, fee schedules, and the index developed under this section. Such report shall include recommendations on how to protect medicare beneficiaries against excessive charges for physician pathology services above the payment amounts established by the fee schedules.

SEC. 4051. ELIMINATION OF MARKUP FOR CERTAIN PURCHASED SERVICES.

(a) IN GENERAL.—Section 1842 of the Social Security Act (42 U.S.C. 1935u) is amended by adding at the end the following new subsection:

"(n)(1) If a physician's bill or a request for payment for services billed by a physician includes a charge to a patient for a diagnostic test described in section 1861(s)(3) (other than a clinical diagnostic laboratory test) for which payment does not indicate that the billing physician personally performed or supervised the performance of the test or that another physician with whom the physician who shares his practice personally performed or supervised the test, the amount payable with respect to the test shall be determined as follows:

"(A) If the bill or request for payment indicates that the test was performed by a supplier, identifies the supplier, and indi-

cates the amount the supplier charged the billing physician, payment for the test (less the applicable deductible and coinsurance amounts) shall be the actual acquisition costs (net of any discounts) or, if lower, the supplier's reasonable charge to individuals enrolled under this part for the test.

"(B) If the bill or request for payment (i) does not indicate who performed the test, or (ii) indicates that the test was performed by a supplier but does not identify the supplier or include the amount charged by the supplier, no payment shall be made under this part.

"(2) A physician may not bill an individual enrolled under this part—

"(A) any amount other than any applicable deductible and coinsurance for a diagnostic test for which payment is made pursuant to paragraph (1)(A), or

"(B) any amount for a diagnostic test for which payment may not be made pursuant to paragraph (1)(B).

"(3) If a physician knowingly and willfully in repeated cases bills one or more individuals in violation of paragraph (2), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2).".

(b) ADJUSTMENT IN MEDICARE PREVAILING CHARGES.—

(1) REVIEW.—The Secretary of Health and Human Services shall review payment levels under part B of title XVIII of the Social Security Act for diagnostic tests (described in section 1861(s)(3) of such Act, but excluding clinical diagnostic laboratory tests) which are commonly performed by independent suppliers, sold as a service to physicians, and billed by such physicians, in order to determine the reasonableness of payment amounts for such tests (and for associated professional services component of such tests). The Secretary may require physicians and suppliers to provide such information on the purchase or sale price (net of any discounts) for such tests as is necessary to complete the review and make the adjustments under this subsection. The Secretary shall also review the reasonableness of payment levels for comparable in-office diagnostic tests.

(2) ESTABLISHMENT OF REVISED PAYMENT SCREENS.—If, as a result of such review, the Secretary determines, after notice and opportunity of at least 60 days for public comment, that the current prevailing charge levels (under the third and fourth sentences of section 1842(b) of the Social Security Act) for any such tests or associated professional services are excessive, the Secretary shall establish such charge levels at levels which, consistent with assuring that the test is widely and consistently available to medicare beneficiaries, reflect a reasonable price for the test without any markup. Alternatively, the Secretary, pursuant to guidelines published after notice and opportunity of at least 60 days for public comment, may delegate to carriers with contracts under section 1842 of the Social Security Act the establishment of new prevailing charge levels under this paragraph. When such charge levels are established, the provisions of section 1842(j)(1)(D) of such Act shall apply in the same manner as they apply to a reduction under section 1842(b)(8)(A) of such Act.

(c) EFFECTIVE DATES.—

(1) The amendment made by subsection (a) shall apply to diagnostic tests performed on or after April 1, 1988.

(2) The Secretary of Health and Human Services shall complete the review and make an appropriate adjustment of prevailing charge levels under subsection (b) for items and services furnished no later than January 1, 1989.

SEC. 4052. COLLECTION OF PAST-DUE AMOUNTS OWED BY PHYSICIANS WHO BREACHED CONTRACTS UNDER THE NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP PROGRAM.

(a) IN GENERAL.—Title XVIII of the Social Security Act, as previously amended by this subtitle, is amended by adding at the end thereof the following new section:

"OFFSET OF PAYMENTS TO PHYSICIANS TO COLLECT PAST-DUE OBLIGATIONS ARISING FROM BREACH OF SCHOLARSHIP CONTRACT

"SEC. 1892. (a) IN GENERAL.—

"(1)(A) Subject to subparagraph (B), the Secretary shall enter into an agreement under this section with any physician who, by reason of a breach of a contract entered into by such physician pursuant to the National Health Service Corps Scholarship Program, owes a past-due obligation to the United States (as defined in subsection (b)).

"(B) The Secretary shall not enter into an agreement with a physician under this section to the extent—

"(i)(I) the physician has entered into a contract with the Secretary pursuant to section 204(a)(1) of the Public Health Service Amendments of 1987, and

"(II) the physician has fulfilled or (as determined by the Secretary) is fulfilling the terms of such contract; or

"(ii) the liability of the physician under such section 204(a)(1) has otherwise been relieved under such section; or

"(iii) the physician is performing such physician's service obligation under a forbearance agreement entered into with the Secretary under subpart II of part D of title III of the Public Health Service Act.

"(2) The agreement under this section shall provide that—

"(A) deductions shall be made from the amounts otherwise payable to the physician under this title, in accordance with a formula and schedule agreed to by the Secretary and the physician, until such past-due obligation (and accrued interest) have been repaid;

"(B) payment under this title for services provided by such physician shall be made only on an assignment-related basis;

"(C) if the physician does not provide services, for which payment would otherwise be made under this title, of a sufficient quantity to maintain the offset collection according to the agreed upon formula and schedule—

"(i) the Secretary shall immediately inform the Attorney General, and the Attorney General shall immediately commence an action to recover the full amount of the past-due obligation, and

"(ii) subject to paragraph (3), the Secretary shall immediately exclude the physician from the program under this title, until such time as the entire past-due obligation has been repaid.

"(3) If the physician refuses to enter into an agreement or breaches any provision of the agreement—

"(A) the Secretary shall immediately inform the Attorney General, and the Attorney General shall immediately commence an action to recover the full amount of the past-due obligation, and

"(B) subject to paragraph (3), the Secretary shall immediately exclude the physician from the program under this title, until such time as the entire past-due obligation has been repaid.

"(4) The Secretary shall not bar a physician pursuant to paragraph (2)(C)(ii) or paragraph (3)(B) if such physician is a sole community physician or sole source of essential specialized services in a community.

"(b) PAST-DUE OBLIGATION.—For purposes of this section, a past-due obligation is any amount—

"(1) owed by a physician to the United States by reason of a breach of a scholarship contract under section 338E of the Public Health Service Act, and

"(2) which has not been paid by the deadline established by the Secretary pursuant to section 338E of the Public Health Service Act, and has not been canceled, waived, or suspended by the Secretary pursuant to such section.

"(c) COLLECTION UNDER THIS SECTION SHALL NOT BE EXCLUSIVE.—This section shall not preclude the United States from applying other provisions of law otherwise applicable to the collection of obligations owed to the United States, including (but not limited to) the use of tax refund offsets pursuant to section 3720A of title 31, United States Code, and the application of other procedures provided under chapter 37 of title 31, United States Code.

"(d) COLLECTION FROM PROVIDERS AND HEALTH MAINTENANCE ORGANIZATIONS.—

"(1) In the case of a physician who owes a past-due obligation, and who is an employee of, or affiliated by a medical services agreement with, a provider having an agreement under section 1866 or a health maintenance organization or competitive medical plan having a contract under section 1833 or section 1876, the Secretary shall deduct the amounts of such past-due obligation from amounts otherwise payable under this title to such provider, organization, or plan.

"(2) Deductions shall be in accordance with a formula and schedule agreed to by the Secretary, the physician and the provider, organization, or plan. The deductions shall be made from the amounts otherwise payable to the physician under this title as long as the physician continued to be employed or affiliated by a medical services agreement.

"(3) Such deduction shall not be made until 6 months after the Secretary notifies the provider, organization, or plan of the amount to be deducted and the particular physicians to whom the deductions are attributable.

"(4) A deduction made under this subsection shall relieve the physician of the obligation (to the extent of the amount collected) to the United States, but the provider, organization, or plan shall have a right of action to collect from such physician the amount deducted pursuant to this subsection (including accumulated interest).

"(5) No deduction shall be made under this subsection if, within the 6-month period after notice is given to the provider, organization, or plan, the physician pays the past-due obligation, or ceases to be employed by the provider, organization, or plan.

"(6) The Secretary shall also apply the provisions of this subsection in the case of a physician who is a member of a group practice, if such group practice submits bills under this program as a group, rather than by individual physicians.

"(e) TRANSFER FROM TRUST FUNDS.—Amounts equal to the amounts deducted pursuant to this section shall be transferred from the Trust Fund from which the payment to the physician, provider, or other entity would otherwise have been made, to the general fund in the Treasury, and shall be credited as payment of the past-due obligation of the physician from whom (or with respect to whom) the deduction was made.".

(b) CONFORMING REFERENCE.—Section 338E(b)(1) of the Public Health Service Act (42 U.S.C. 254o(b)(1)) is amended by adding at the end thereof the following new sentence: "Amounts not paid within such period shall be subject to collection through deductions in Medicare payments pursuant to section 1892 of the Social Security Act.".

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective on the date of the enactment of this Act.

SEC. 4052. ELIMINATION OF 1975 FLOOR FOR PREVAILING PHYSICIAN CHARGES.

(a) IN GENERAL.—Section 1842(b)(3) of the Social Security Act (42 U.S.C. 1395u(b)(3)) is amended by striking the next-to-last sentence (which begins "Notwithstanding the provisions of").

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to payment for services furnished on or after January 1, 1988.

SEC. 4053. APPLICATION OF MAXIMUM ALLOWABLE ACTUAL CHARGE (MAAC).

(a) APPLICATION ON INDIVIDUAL CHARGE BASIS.—Section 1842(j)(1) of the Social Security Act (42 U.S.C. 1395u(j)(1)) is amended—

(1) in the first sentence of subparagraph (B)(i), by striking "each such physician's actual charges" and inserting "the actual charges of each such physician";

(2) in the second sentence of subparagraph (B)(i), by striking "for such a service a physician's actual charge (as defined in subparagraph (C)(vi)" and inserting "on a repeated basis for such a service an actual charge"; and

(3) in subparagraph (C)(vi), by striking "and subparagraph (B)".

(b) ADJUSTMENT.—In the case of a physician who did not have actual charges under title XVIII of the Social Security Act for a

procedure in the calendar quarter beginning on April 1, 1984, but who establishes to the satisfaction of a carrier that he or she had actual charges (whether under such title or otherwise) for the procedure performed prior to June 30, 1984, the carrier shall compute the maximum allowable actual charge under section 1842(j) of the Social Security Act for such procedure performed by such physician in 1988 based on such physician's actual charges for the procedure.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to charges imposed for services furnished on or after April 1, 1988.

SEC. 4054. APPLYING COPAYMENT AND DEDUCTIBLE TO CERTAIN OUTPATIENT PHYSICIANS' SERVICES.

Notwithstanding any other provision of law, payment under part B of title XVIII of the Social Security Act for physicians' services specified in section 1833(i)(1) of such Act and furnished on or after April 1, 1988, in an ambulatory surgical center or hospital outpatient department on an assignment-related basis shall be subject to the deductible under section 1833(b) of such Act and 20 percent coinsurance.

SEC. 4055. PHYSICIAN PAYMENT STUDIES.

(a) DEFINITIONS OF MEDICAL AND SURGICAL PROCEDURES.—

(1) REPORT ON VARIATIONS IN CARRIER PAYMENT PRACTICE.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall conduct a study of variations in payment practices for physicians' services among the different carriers under section 1842 of the Social Security Act. Such study shall examine carrier variations in the services included in global fees and pre- and post-operative services included in payment for the operation. The Secretary shall report to Congress on such study by not later than May 1, 1988.

(2) UNIFORM DEFINITIONS OF PROCEDURES FOR PAYMENT PURPOSES.—The Secretary shall develop, in consultation with appropriate national medical specialty societies and by not later than July 1, 1989, uniform definitions of physicians' services (including appropriate classification scheme for procedures) which could serve as the basis for making payments for such services under part B of title XVIII of the Social Security Act. In developing such list, to the extent practicable—

(A) ancillary services commonly performed in conjunction with a major procedure would be included with the major procedure;

(B) pre- and post-procedure services would be included in the procedure; and

(C) similar procedures would be listed together if the procedures are similar in resource requirements.

(b) EXPANSION OF RELATIVE VALUE SCALE (RVS) STUDY.—

(1) ADDITIONAL SERVICES.—The Secretary shall expand the study being conducted, under section 1845(e) of the Social Security Act, to develop a relative value scale for physicians' services to include physicians' services in the fields of cardiology, dermatology, emergency medicine, gastroenterology, hematology, infectious disease, nephrology, neurology, neurosurgery, nuclear medicine, oncology, physical medicine and rehabilitation, plas-

tic surgery, pulmonary medicine, and radiation therapy, and for physicians who specialize in osteopathic procedures.

(2) NO DELAY IN CURRENT STUDY.—The expansion under paragraph (1) shall not be conducted in a manner that delays the completion of the current study or the report to Congress required under section 1845(e)(3) of the Social Security Act. The Secretary shall report to Congress on the services described in paragraph (1) by not later than October 1, 1989.

(3) PROMPT SUBMITTAL OF STUDY RESULTS TO PHYSICIAN PAYMENT REVIEW COMMISSION.—The Secretary shall submit to the Physician Payment Review Commission a copy of any report submitted to the Secretary pursuant to a cooperative agreement in the fulfillment of the requirement of section 1845(e) of such Act, with all relevant supporting data (including survey data, analytic data files, and file documentation), by no later than 30 days after the date the final report is received by the Secretary.

(c) OTHER PHYSICIAN PAYMENT STUDIES.—

(1) FEE SCHEDULE IMPLEMENTATION.—The Secretary shall conduct a study of changes in the payment system for physicians' services, under part B of title XVIII of the Social Security Act, that would be required for the implementation of a national fee schedule for such services furnished on or after January 1, 1990. Such study shall identify any major technical problems related to such implementation and recommendations on ways in which to address such problems. The Secretary shall report to the Congress on such study by not later than July 1, 1989.

(2) VOLUME AND INTENSITY OF PHYSICIAN SERVICES.—The Secretary shall conduct a study of issues relating to the volume and intensity of physicians' services under part B of title XVIII of the Social Security Act, including—

(A) historical trends with regard to increases in the volume and intensity of physicians' services furnished on a per enrollee basis (with appropriate adjustments to account for changes in the demographic composition of the medicare population);

(B) geographic variations in volume and intensity in physicians' services;

(C) an analysis of the effectiveness of methods currently used under such part to ensure that payments under such part are made only for services which are medically necessary;

(D) the development and analysis of alternative methods to control the volume of services; and

(E) the impact of the implementation of the relative value scale developed under section 1845(e) of such Act on the volume and intensity of physicians' services.

The Secretary shall submit to Congress an interim report on such study not later than May 1, 1988, and a final report on such study not later than May 1, 1989.

(3) SURVEY OF OUT-OF-POCKET COSTS OF MEDICARE BENEFICIARIES FOR HEALTH CARE SERVICES.—The Secretary shall conduct a survey to determine the distribution of—

(A) the liabilities and expenditures for health care services of individuals entitled to benefits under title XVIII of

the Social Security Act, including liabilities for charges (not paid on an assignment-related basis) in excess of the reasonable charge recognized, and

(B) the collection rates among different classes of physicians for such liabilities, including collection rates for required coinsurance and for charges (not paid on an assignment-related basis) in excess of the reasonable charge recognized.

The Secretary shall report to Congress on such study by not later than July 1, 1990.

(d) STUDY OF PAYMENT FOR CHEMOTHERAPY IN PHYSICIANS' OFFICES.—

(1) IN GENERAL.—The Secretary shall study ways of modifying part B of title XVIII of the Social Security Act to permit adequate payment under such part for the costs associated with providing chemotherapy to cancer patients in physicians' offices. The study shall be performed in consultation with physicians and other health care providers who are experts in cancer therapy and with representation of health insurers who have experience in these payment issues.

(2) REPORT.—The Secretary shall report to Congress on the results of the study by not later than April 1, 1989.

Subpart B—Provisions Relating to Payments for Other Services

SEC. 4061. EXTENSION OF REDUCTION FOR OTHER PART B ITEMS AND SERVICES PAYMENTS UNDER SEQUESTER ORDER.

Notwithstanding any other provision of law (including any other provision of this Act), the reductions in the amount of payments required under title XVIII of the Social Security Act made by the final sequester order issued by the President on November 20, 1987, pursuant to section 252(b) of the Balanced Budget Emergency Deficit Control Act of 1985 shall continue to be effective (as provided by sections 252(a)(4)(B) and 256(d)(2) of such Act) through March 31, 1988, with respect to payments for all items and services (other than physicians' services) under part B of such title.

SEC. 4062. PAYMENTS FOR DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETICS.

(a) 1-YEAR FREEZE ON CHARGE LIMITATIONS.—

(1) IN GENERAL.—In imposing limitations on allowable charges for items and services (other than physicians' services) furnished in 1988 under part B of title XVIII of such Act and for which payment is made on the basis of the reasonable charge for the item or service, the Secretary of Health and Human Services shall not impose any limitation at a level higher than the same level as was in effect in December 1987.

(2) TRANSITION.—The provisions of section 4041(a)(2) (other than subparagraph (D) thereof) of this subtitle shall apply to suppliers of items and services described in paragraph (1), and directories of participating suppliers of such items and services, in the same manner as such section applies to physicians fur-

nishing physicians' services, and directories of participating physicians.

(b) AMOUNT AND FREQUENCY OF PAYMENT FOR DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETICS.—Part B of title XVIII of the Social Security Act is amended by inserting after section 1833 the following new section:

"SPECIAL PAYMENT RULES FOR PARTICULAR SERVICES

"SEC. 1834. (a) PAYMENT FOR DURABLE MEDICAL EQUIPMENT, PROSTHETIC DEVICES, ORTHOTICS, AND PROSTHETICS.—

"(1) GENERAL RULE FOR PAYMENT.—

"(A) IN GENERAL.—With respect to a covered item (as defined in paragraph (13)) for which payment is determined under this subsection, payment shall be made in the frequency specified in paragraphs (2) through (7) and in an amount equal to 80 percent of the payment basis described in subparagraph (B).

"(B) PAYMENT BASIS.—The payment basis described in this subparagraph is the lesser of—

"(i) the actual charge for the item, or

"(ii) the payment amount recognized under paragraphs (2) through (7) of this subsection for the item;

except that clause (i) shall not apply if the covered item is furnished by a public home health agency (or by another home health agency which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low income) free of charge or at nominal charges to the public.

"(C) EXCLUSIVE PAYMENT RULE.—This subsection shall constitute the exclusive provision of this title for payment for covered items under this part.

"(2) PAYMENT FOR INEXPENSIVE AND OTHER ROUTINELY PURCHASED DURABLE MEDICAL EQUIPMENT.—

"(A) IN GENERAL.—Payment for an item of durable medical equipment (as defined in paragraph (13)(A))—

"(i) the purchase price of which does not exceed $150, or

"(ii) which the Secretary determines is acquired at least 75 percent of the time by purchase,

shall be made on a rental basis or in a lump-sum amount for the purchase of the item. The payment amount recognized for purchase or rental of such equipment is the amount specified in subparagraph (B) for purchase or rental, except that the total amount of rental payments with respect to an item may not exceed the payment amount specified in subparagraph (B) with respect to the purchase of the item.

"(B) PAYMENT AMOUNT.—For purposes of subparagraph (A), the amount specified in this subparagraph, with respect to the purchase or rental of an item furnished in a carrier service area—

"(i) in 1989 is the average allowed charge in the area for the purchase or rental, respectively, of the item for

the 12-month period ending on June 30, 1987, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987; or

"(ii) in a subsequent year, is the amount specified in this subparagraph for the preceding year increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of that preceding year.

"(3) PAYMENT FOR ITEMS REQUIRING FREQUENT AND SUBSTANTIAL SERVICING.—

"(A) IN GENERAL.—Payment for a covered item (such as ventilators , aspirators, IPPB machines, and nebulizers) for which there must be frequent and substantial servicing in order to avoid risk to the patient's health shall be made on a monthly basis for the rental of the item and the amount recognized is the amount specified in subparagraph (B).

"(B) PAYMENT AMOUNT.—For purposes of subparagraph (A), the amount specified in this subparagraph, with respect to an item or device furnished in a carrier service area—

"(i) in 1989 is the average allowable charge in the area for the rental of the item or device for the 12-month period ending with June, 1987, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987; or

"(ii) in a subsequent year, is the amount specified in this subparagraph for the preceding year increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of that preceding year.

"(4) PAYMENT FOR CERTAIN CUSTOMIZED ITEMS.—Payment with respect to a covered item that is uniquely constructed or substantially modified to meet the specific needs of an individual patient shall be made in a lump-sum amount for the purchase of the item in a payment amount based upon the carrier's individual consideration for that item, and for the reasonable and necessary maintenance and service for parts and labor not covered by the supplier's or manufacturer's warranty, when necessary during the period of medical need, and the amount recognized for such maintenance and service shall be paid on a lump-sum, as needed basis based upon the carrier's individual consideration for that item.

"(5) PAYMENT FOR OXYGEN AND OXYGEN EQUIPMENT.—

"(A) IN GENERAL.—Payment for oxygen and oxygen equipment shall be made on a monthly basis in the monthly payment amount recognized under paragraph (9) for oxygen and oxygen equipment (other than portable oxygen equipment), subject to subparagraphs (B) and (C).

"(B) ADD-ON FOR PORTABLE OXYGEN EQUIPMENT.—When portable oxygen equipment is used, but subject to subparagraph (D), the payment amount recognized under subparagraph (A) shall be increased by the monthly payment

amount recognized under paragraph (9) for portable oxygen equipment.

"(C) VOLUME ADJUSTMENT.—When the attending physician prescribes an oxygen flow rate—

"(i) exceeding 4 liters per minute, the payment amount recognized under subparagraph (A), subject to subparagraph (D), shall be increased by 50 percent, or

"(ii) of less than 1 liter per minute, the payment amount recognized under subparagraph (A) shall be decreased by 50 percent.

"(D) LIMIT ON ADJUSTMENT.—When portable oxygen equipment is used and the attending physician prescribes an oxygen flow rate exceeding 4 liters per minute, there shall only be an increase under either subparagraph (B) or (C), whichever increase is larger, and not under both such subparagraphs.

"(6) PAYMENT FOR OTHER COVERED ITEMS (OTHER THAN DURABLE MEDICAL EQUIPMENT).—Payment for other covered items (other than durable medical equipment and other covered items described in paragraph (3), (4), or (5)) shall be made in a lump-sum amount for the purchase of the item in the amount of the purchase price recognized under paragraph (8).

"(7) PAYMENT FOR OTHER ITEMS OF DURABLE MEDICAL EQUIPMENT.—

"(A) IN GENERAL.—In the case of an item of durable medical equipment not described in paragraphs (2) through (6)—

"(i) payment shall be made on a monthly basis for the rental of such item during the period of medical need (but payments under this subparagraph may not extend over a period of continuous use of longer than 15 months), and, subject to subparagraph (B), the amount recognized for each such month is 10 percent of the purchase price recognized under paragraph (8) with respect to the item;

"(ii) during the succeeding 6-month period of medical need, no payment shall be made for rental or servicing of the item; and

"(iii) during the first month of each succeeding 6-month period of medical need, a service and maintenance payment may be made (for parts and labor not covered by the supplier's or manufacturer's warranty, as determined by the Secretary to be appropriate for the particular type of durable medical equipment) and the amount recognized for each such 6-month period is the lower of (I) a reasonable and necessary maintenance and servicing fee established by the carrier, or (II) 10 percent of the total of the purchase price recognized under paragraph (8) with respect to the item.

The Secretary shall determine the meaning of the term 'continuous' in subparagraph (A).

"(B) RANGE FOR RENTAL AMOUNTS.—

"(i) FOR 1989.—For items furnished during 1989, the payment amount recognized under subparagraph (A)(i)

shall not be more than 115 percent, and shall not be less than 85 percent, of the prevailing charge established for rental of the item January 1987, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987.

"(ii) FOR 1990.—For items furnished during 1990, the payment amount recognized under subparagraph (A)(i) shall not be more than the maximum amount established under clause (i), and shall not be less than the minimum amount established under such clause, for 1989, each such amount increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June 1989.

"(8) PURCHASE PRICE RECOGNIZED FOR MISCELLANEOUS DEVICES AND ITEMS.—For purposes of paragraphs (6) and (7), the amount that is recognized under this paragraph as the purchase price for a covered item is the amount described in subparagraph (C) of this paragraph, determined as follows:

"(A) COMPUTATION OF LOCAL PURCHASE PRICE.—Each carrier under section 1842 shall compute a base local purchase price for the item as follows:

"(i) The carrier shall compute a base local purchase price, for each item described—

"(I) in paragraph (6) equal to the average allowable charge in the locality for the purchase of the item for the 12-month period ending with June 1987, or

"(II) in paragraph (7) equal to the average of the purchase prices on the claims submitted on an assignment-related basis for the unused item supplied during the 6-month period ending with December 1986.

"(ii) The carrier shall compute a local purchase price, with respect to the furnishing of each particular item—

"(I) in 1989, equal to the base local purchase price computed under clause (i) increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987, or

"(II) in 1990, 1991, or 1992, equal to the local purchase price computed under this clause for the previous year increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

"(B) COMPUTATION OF REGIONAL PURCHASE PRICE.—With respect to the furnishing of a particular item in each region (as defined in section 1886(d)(2)(D)), the Secretary shall compute a regional purchase price—

"(i) for 1991, and for 1992, equal to the average (weighted by relative volume of all claims among carri-

ers) of the local purchase prices for the carriers in the region computed under subparagraph (A)(ii)(II) for the year, and

"(ii) for each subsequent year, equal to the regional purchase price computed under this subparagraph for the previous year increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

"(C) PURCHASE PRICE RECOGNIZED.—For purposes of paragraphs (6) and (7) and subject to subparagraph (D), the amount that is recognized under this paragraph as the purchase price for each item furnished—

"(i) in 1989 or 1990, is 100 percent of the local purchase price computed under subparagraph (A)(ii)(I);

"(ii) in 1991, is the sum of (I) 75 percent of the local purchase price computed under subparagraph (A)(ii)(II) for 1991, and (II) 25 percent of the regional purchase price computed under subparagraph (B) for 1991;

"(iii) in 1992, is the sum of (I) 50 percent of the local purchase price computed under subparagraph (A)(ii)(II) for 1992, and (II) 50 percent of the regional purchase price computed under subparagraph (B) for 1992; and

"(iv) in 1993 or a subsequent year, is the regional purchase price computed under subparagraph (B) for that year.

"(D) RANGE ON AMOUNT RECOGNIZED.—The amount that is recognized under subparagraph (C) as the purchase price for an item furnished—

"(i) in 1991, may not exceed 130 percent, and may not be lower than 80 percent, of the average of the purchase prices recognized under such subparagraph for all the carrier service areas in the United States in that year; and

"(ii) in a subsequent year, may not exceed 125 percent, and may not be lower than 85 percent, of the average of the purchase prices recognized under such subparagraph for all the carrier service areas in the United States in that year.

"(9) MONTHLY PAYMENT AMOUNT RECOGNIZED WITH RESPECT TO OXYGEN AND OXYGEN EQUIPMENT.—For purposes of paragraph (5), the amount that is recognized under this paragraph for payment for oxygen and oxygen equipment is the monthly payment amount described in subparagraph (C) of this paragraph. Such amount shall be computed separately (i) for all items of oxygen and oxygen equipment (other than portable oxygen equipment) and (ii) for portable oxygen equipment (each such group referred to in this paragraph as an 'item').

"(A) COMPUTATION OF LOCAL MONTHLY PAYMENT RATE.—Each carrier under this section shall compute a base local payment rate for each item as follows:

"(i) The carrier shall compute a base local average monthly payment rate per beneficiary as an amount equal to (I) the total reasonable charges for the item

during the 12-month period ending with December 1986, divided by (II) the total number of months for all beneficiaries receiving the item in the area during the 12-month period for which the carrier made payment for the item under this title.

"(ii) The carrier shall compute a local average monthly payment rate for the item applicable—

"(I) to 1989, equal to 95 percent of the base local average monthly payment rate computed under clause (i) for the item increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 6-month period ending with December 1987, or

"(II) to 1990 and to 1991, equal to the local average monthly payment rate computed under this clause for the item for the previous year increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

"(B) COMPUTATION OF REGIONAL MONTHLY PAYMENT RATE.—With respect to the furnishing of an item in each region (as defined in section 1886(d)(2)(D)), the Secretary shall compute a regional monthly payment rate—

"(i) for 1991, and 1992, equal to the average (weighted by relative volume of all claims among carriers) of the local monthly payment rates for the carriers in the region computed under subparagraph (A)(ii)(II) for the year, and

"(ii) for each subsequent year, equal to the regional monthly payment rates computed under this subparagraph for the previous year increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

"(C) MONTHLY PAYMENT AMOUNT RECOGNIZED.—For purposes of paragraph (5), the amount that is recognized under this paragraph as the base monthly payment amount for each item furnished—

"(i) in 1989 and in 1990, is 100 percent of the local average monthly payment rate computed under subparagraph (A)(ii)(I) for the item;

"(ii) in 1991, is the sum of (I) 75 percent of the local average monthly payment rate computed under subparagraph (A)(ii)(II) for the item for 1991, and (II) 25 percent of the regional monthly payment rate computed under subparagraph (B)(i) for the item for 1991;

"(iii) in 1992, is the sum of (I) 50 percent of the local average monthly payment rate computed under subparagraph (A)(ii)(II) for the item for 1992, and (II) 50 percent of the regional monthly payment rate computed under subparagraph (B)(i) for the item for 1992; and

"(iv) in a subsequent year, is the regional monthly payment rate computed under subparagraph (B) for the item for that year.

"(D) RANGE ON AMOUNT RECOGNIZED.—The amount that is recognized under subparagraph (C) as the base monthly payment amount for an item furnished—

"(i) in 1991, may not exceed 130 percent, and may not be lower than 80 percent, of the average of the base monthly payment amounts recognized under such subparagraph for all the carrier service areas in the United States in that year; and

"(ii) in a subsequent year, may not exceed 125 percent, and may not be lower than 85 percent, of the average of the base monthly payment amounts recognized under such subparagraph for all the carrier service areas in the United States in that year.

"(10) EXCEPTIONS AND ADJUSTMENTS.—

"(A) AREAS OUTSIDE CONTINENTAL UNITED STATES.—Exceptions to the amounts recognized under the previous provisions of this subsection shall be made to take into account the unique circumstances of covered items furnished in Alaska, Hawaii, or Puerto Rico.

"(B) ADJUSTMENT FOR INHERENT REASONABLENESS.—For covered items furnished on or after January 1, 1991, the Secretary is authorized to apply the provisions of paragraphs (8) and (9) (other than subparagraph (D)) of section 1842(b) to covered items and suppliers of such items.

"(C) TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS).—In order to permit an attending physician time to determine whether the purchase of a transcutaneous electrical nerve stimulator is medically appropriate for a particular patient, the Secretary may determine an appropriate payment amount for the initial rental of such item for a period of not more than 2 months. If such item is subsequently purchased, the payment amount with respect to such purchase is the payment amount determined under paragraph (2).

"(11) IMPROPER BILLING AND REQUIREMENT OF PHYSICIAN ORDER.—

"(A) IMPROPER BILLING FOR CERTAIN RENTAL ITEMS.—Notwithstanding any other provision of this title, a supplier of a covered item for which payment is made under this subsection and which is furnished on a rental basis shall continue to supply the item without charge (other than a charge provided under this subsection for the servicing of the item) after rental payments may no longer be made under this subsection. If a supplier knowingly and willfully violates the previous sentence, the Secretary may apply sanctions against the supplier under subsection (j)(2) in the same manner such sanctions may apply with respect to a physician.

"(B) REQUIREMENT OF PHYSICIAN ORDER.—The Secretary is authorized to require, for specified covered items, that payment may be made under this subsection with respect to

the item only if a physician has communicated to the supplier, before delivery of the item, a written order for the item.

"(12) REGIONAL CARRIERS.—The Secretary may designate, by regulation under section 1842, one carrier for each region (as defined in section 1886(d)(2)(D)) to process all claims within the region for covered items under this section.

"(13) COVERED ITEM.—In this subsection, the term 'covered item' means—

"(A) durable medical equipment (as defined in section 1861(n)), including such equipment described in section 1861(m)(5);

"(B) prosthetic devices (described in section 1861(s)(8)), but not including parenteral and enteral nutrition nutrients, supplies, and equipment; and

"(C) orthotics and prosthetics (described in section 1861(s)(9));

but does not include intraocular lenses.

"(14) CARRIER.—In this subsection, any reference to the term 'carrier' includes a reference, with respect to durable medical equipment furnished by a home health agency as part of home health services, to a fiscal intermediary.".

(c) STUDY AND EVALUATION.—(1) The Secretary of Health and Human Services shall monitor the impact of the amendments made by this section on the availability of covered items and shall evaluate the appropriateness of the volume adjustment for oxygen and oxygen equipment under section 1834(a)(5)(C) of the Social Security Act (as amended by subsection (b) of this section). The Secretary shall report to Congress, by not later than January 1, 1991, on such impact and on the evaluation and shall include in such report recommendations for changes in payment methodology for covered items under section 1834(a) of such Act.

(2) Before January 1, 1991, the Secretary may not conduct any demonstration project respecting alternative methods of payment for covered items under title XVIII of the Social Security Act.

(3) In this subsection, the term "covered item" has the meaning given such term in section 1834(a)(13) of the Social Security Act (as amended by subsection (b) of this section).

(4) The Secretary shall, upon written request, provide the data and information used in determining the payment amounts for covered items under section 1834(a) of the Social Security Act.

(5) The Comptroller General shall conduct a study on the appropriateness of the level of payments allowed for covered items under the medicare program, and shall report to Congress on the results of such study (including recommendations on the transition to regional or national rates) by not later than January 1, 1991. Entities furnishing such items which fail to provide the Comptroller General with reasonable access to necessary records to carry out the study under this paragraph are subject to exclusion from the medicare program under section 1128(a) of the Social Security Act.

(d) CONFORMING AMENDMENTS.—

(1) Section 1814 of such Act (42 U.S.C. 1395f) is amended—

(A) in subsection (j)(2)(B), by amending subparagraph (B) to read as follows:

"(B) Section 1834(a)(1)(B).", and

(B) in subsection (k), by striking all that follows "shall be" and insert "the amount described in section 1834(a)(1).".

(2) Section 1832(a) of such Act (42 U.S.C. 1395k(a)) is amended—

(A) in paragraph (2)(A), by inserting "(other than items described in subparagraph (G))" after "services";

(B) in paragraph (2)(B), by inserting "(other than items described in subparagraph (G))" after "medical and other health services"; and

(C) in paragraph (2)—

(i) by striking "and" at the end of subparagraph (E),

(ii) by striking the period at the end of subparagraph (F) and inserting "; and", and

(iii) by adding at the end the following new subparagraph:

"(G) covered items (described in section 1834(a)(13)) furnished by a provider of services or by others under arrangements with them made by a provider of services.".

(3) Section 1833(a) of such Act (42 U.S.C. 1395l(a)) is amended—

(A) in paragraph (1)—

(i) by striking "; and" at the end of clause (G) and inserting a comma, and

(ii) by adding at the end the following: "and (I) with respect to covered items (described in section 1834(a)(13)), the amounts paid shall be the amounts described in section 1834(a)(1),";

(B) in paragraph (2)—

(i) by striking "and (F)" and inserting "(F), and (G)", and

(ii) in subparagraph (A), by striking "(other than durable medical equipment)";

(B) by striking "and" at the end of paragraph (3);

(C) by striking the period at the end of paragraph (4) and inserting "; and"; and

(D) by adding at the end the following new paragraph:

"(5) in the case of covered items (described in section 1834(a)(13)) the amounts described in section 1834(a)(1).".

(4) Section 1866(a)(2)(A) of such Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by adding at the end the following new sentence: "Notwithstanding the first sentence of this subparagraph, a home health agency may charge such an individual or person, with respect to covered items subject to payment under section 1834(a), the amount of any deduction imposed under section 1833(b) and 20 percent of the payment basis described in section 1834(a)(2).".

(5) Section 1889 of such Act (42 U.S.C. 1395zz) is repealed.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to covered items furnished on or after January 1, 1989.

SEC. 4063. PAYMENT FOR INTRAOCULAR LENSES.

(a) PROVIDED IN PHYSICIAN'S OFFICE.—Section 1842 of the Social Security Act (42 .U.S.C. 1395u), as previously amended is amended—

(1) in subsection (b)(11)(C), as inserted by section 4046(a)(1)(C) of this subtitle—

"(A) by inserting "(i)" after "(C)" and by adding at the end the following new clause:

"(ii) The reasonable charge for an intraocular lens implanted during cataract surgery in a physician's office may not exceed the actual acquisition cost for the lens (taking into account any discount) plus a handling fee (not to exceed 5 percent of such actual acquisition cost).", and

(C) in subparagraph (D), as so redesignated and as amended by section 4046(a)(1) of this subtitle, by inserting "or item" after "service" or "services" each place either appears; and

(2) in subsection (j)(1)(D), as added by section 4045(c)(1)(B) of this subtitle and as amended by 4046(a)(2) of this subtitle—

(A) in clause (ii), by striking "and" at the end of subclause (IV), by redesignating subclause (V) as subclause (VI) and by inserting before such subclause the following new subclause:

"(IV) a reasonable charge limit is established under subsection (b)(11)(C)(ii), and"; and

(B) in clause (iii)—

(i) by striking "or" at the end of subclause (I),

(ii) in subclause (II), by striking "(b)(11)(C)" and inserting "(b)(11)(C)(i)",

(iii) by striking the period at the end of subclause (II) and inserting "; or", and

(iv) by adding at the end the following new subclause:

"(III) under subsection (b)(11)(C)(ii), the payment allowance established under such subsection.".

(b) PROVIDED IN AMBULATORY SURGICAL CENTERS.—Section 1833(i)(2)(A) of such Act (42 U.S.C. 1395l(i)(2)(A)) is amended—

(1) by striking "and" at the end of clause (i),

(2) by striking the period at the end of clause (ii) and inserting ", and", and

(3) by inserting after clause (ii) the following new clause:

"(iii) in the case of implantation of an intraocular lens during cataract surgery includes payment which is reasonable and related to the cost of acquiring the class of lens involved.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items furnished on or after July 1, 1988.

(d) SPECIAL RULE.—With respect to the establishment of a reasonable charge limit under section 1842(b)(11)(C)(ii) of the Social Security Act, in applying section 1842(j)(1)(D)(i) of such Act, the matter beginning with "plus" shall be considered to have been deleted.

SEC. 4064. CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) LIMITATION ON CHANGES IN FEE SCHEDULES.—

(1) 3-MONTH FREEZE IN FEE SCHEDULES.—Notwithstanding any other provision of law, any change in the fee schedules for

clinical laboratory diagnostic laboratory tests under part B of title XVIII of such Act which would have become effective for tests furnished on or after January 1, 1988, shall not be effective for tests furnished during the 3-month period beginning on January 1, 1988.

(2) NO CPI INCREASE IN 1988.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not adjust the fee schedules established under section 1833(h) of the Social Security Act for 1988 to take into account any increase in the consumer price index.

(b) FEE SCHEDULES AND PAYMENT LIMITS.—

(1) REBASING OF FEE SCHEDULES FOR CERTAIN AUTOMATED AND SIMILAR TESTS.—Section 1833(h)(2) of the Social Security Act (42 U.S.C. 1395l(h)(2)) is amended by adding at the end the following: "In establishing fee schedules under the first sentence of this paragraph with respect to automated tests and tests (other than cytopathology tests) which before July 1, 1984, the Secretary made subject to a limit based on lowest charge levels under the sixth sentence of section 1842(b)(3) performed after March 31, 1988, the Secretary shall reduce by 8.3 percent the fee schedules otherwise established for 1988.".

(2) NATIONWIDE PAYMENT LIMITS.—Section 1833(h)(4)(B) of such Act is amended—

(A) in clause (i), by striking "January" and inserting "April", and

(B) by amending clause (ii) to read as follows:

"(ii) March 31, 1988, and so long as a fee schedule for the test has not been established on a nationwide basis, is equal to the median of all the fee schedules established for that test for that laboratory setting under paragraph (1).".

(3) EFFECTIVE DATES.—The amendments made by paragraphs (1) and (2) shall apply with respect to services furnished on or after April 1, 1988.

(4) GAO STUDY OF FEE SCHEDULES.—The Comptroller General shall conduct a study of the level of the fee schedules established for clinical diagnostic laboratory services under section 1833(h)(2) of the Social Security Act to determine, based on the costs of, and revenues received for, such tests the appropriateness of such schedules. The Comptroller General shall report to the Congress on the results of such study by not later than January 1, 1990. Suppliers of such tests which fail to provide the Comptroller General with reasonable access to necessary records to carry out the study under this paragraph are subject to exclusion from the medicare program under section 1128(a) of the Social Security Act.

(c) LIMITATION ON APPLICATION OF 2 PERCENT HOSPITAL LAB DIFFERENTIAL.—Section 1833(h)(2) of such Act is amended by striking "hospital laboratory" and inserting "laboratory in a sole community hospital".

(d) INTERMEDIATE SANCTIONS.—

(1) Part B of title XVIII of such Act is amended by adding at the end thereof the following new section:

"INTERMEDIATE SANCTIONS FOR PROVIDERS OF CLINICAL DIAGNOSTIC LABORATORY TESTS"

"SEC. 1846. (a) If the Secretary determines that any provider or clinical laboratory certified for participation under this title no longer substantially meets the conditions of participation specified under this title with respect to the provision of clinical diagnostic laboratory tests under this part, the Secretary may (for a period not to exceed one year) impose intermediate sanctions developed pursuant to subsection (b), in lieu of canceling immediately the certification of the provider or clinical laboratory.

"(b)(1) The Secretary shall develop and implement—

"(A) a range of intermediate sanctions to apply to providers or certified clinical laboratories under the conditions described in subsection (a), and

"(B) appropriate procedures for appealing determinations relating to the imposition of such sanctions.

"(2)(A) The intermediate sanctions developed under paragraph (1) shall include—

"(i) directed plans of correction,

"(ii) civil fines and penalties,

"(iii) payment for the costs of onsite monitoring by an agency responsible for conducting certification surveys, and

"(iv) suspension of all or part of the payments to which a provider or certified clinical laboratory would otherwise be entitled under this title with respect to clinical diagnostic laboratory tests provided on or after the date in which the Secretary determines that intermediate sanctions should be imposed pursuant to subsection (a).

"(B) The sanctions specified in subparagraph (A) are in addition to sanctions otherwise available under State or Federal law.

"(3) The Secretary shall develop and implement specific procedures with respect to when and how each of the intermediate sanctions developed under paragraph (1) is to be applied, the amounts of any fines, and the severity of each of these penalties. Such procedures shall be designed so as to minimize the time between identification of violations and imposition of these sanctions and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies.".

(2) The amendment made by paragraph (1) shall become effective on January 1, 1990.

(e) STATE CERTIFICATION OF HIGH-VOLUME PHYSICIAN OFFICE LABS.—

(1) Section 1861(s) of such Act (42 U.S.C. 1395x(s)) is amended, in the sentence following paragraph (11), by inserting "a laboratory not independent of a physician's office that has a volume of clinical diagnostic laboratory tests exceeding 5,000 per year" after "physician's office,".

(2) The amendment made by paragraph (1) shall apply to diagnostic tests performed on or after January 1, 1990.

SEC. 4065. RETURN ON EQUITY PAYMENTS TO OUTPATIENT DEPARTMENTS.

(a) IN GENERAL.—Section 1861(v)(1) of the Social Security Act (42 U.S.C. 1395x(v)(1)) is amended by adding at the end thereof the following new subparagraph:

"(S) Such regulations shall not include provision for specific recognition of any return on equity capital with respect to hospital outpatient departments.".

(b) CONFORMING AMENDMENT.—Section 1881(b)(2)(C) of such Act (42 U.S.C. 1395rr(b)(2)(C)) is amended by striking "facilities" and inserting "facilities (other than hospital outpatient departments)".

(c) EFFECTIVE DATE.—The amendments made by this section shall become effective on January 1, 1988.

SEC. 4066. PAYMENTS TO HOSPITAL OUTPATIENT DEPARTMENTS FOR RADIOLOGY.

(a) AMOUNTS PAYABLE.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended—

(1) in subsection (a)(2)—

(A) by striking "and" in subparagraph (C),

(B) by adding "and" at the end of subparagraph (D), and

(C) by adding at the end thereof the following new subparagraph:

"(E) with respect to—

"(i) outpatient hospital radiology services (including diagnostic and therapeutic radiology, nuclear medicine and CAT scan procedures, magnetic resonance imaging, and ultrasound and other imaging services), and

"(ii) effective for procedures performed on or after October 1, 1989, diagnostic procedures (as defined by the Secretary) described in section 1861(s)(3) (other than diagnostic X-ray tests and diagnostic laboratory tests),

the amount determined under subsection (n);"; and

(2) by adding at the end, as previously amended, the following new subsection:

"(n)(1)(A) The aggregate amount of the payments to be made for all or part of a cost reporting period beginning on or after October 1, 1988 under this part for services described in subsection (a)(2)(E) shall be equal to the lesser of—

"(i) the amount determined with respect to such services under subsection (a)(2)(B), or

"(ii) the blend amount for radiology services and diagnostic procedures determined in accordance with subparagraph (B).

"(B)(i) The blend amount for radiology services and diagnostic procedures for a cost reporting period is the sum of—

"(I) the cost proportion (as defined in clause (ii)) of the amount described in subparagraph (A)(i); and

"(II) the charge proportion (as defined in clause (ii)(II)) of 62 percent (for services described in subsection (a)(2)(E)(i)), or (for procedures described in subsection (a)(2)(E)(ii)), 42 percent or such other percent established by the Secretary (or carriers acting pursuant to guidelines issued by the Secretary) based on prevailing charges established with actual charge data, of 80 percent of the prevailing charge for participating physicians for the same services as if they were furnished in a physician's office in the same locality as determined under section 1842(b).

"(ii) In this subparagraph:

"(I) The term 'cost proportion' means 65 percent for all or any part of cost reporting periods which occur in fiscal year 1989 and 50 percent for other cost reporting periods.

"(II) The term 'charge proportion' means 35 percent for all or any parts of cost reporting periods which occur in fiscal year 1989 and 50 percent for other cost reporting periods.".

(b) CONFORMING AMENDMENT.—Section 1833(a)(2)(B) of such Act (42 U.S.C. 1395l(a)(2)(B)) is amended in the matter preceding clause (i) by striking "(C) or (D)" and inserting "(C), (D), or (E)".

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to outpatient hospital radiology services furnished on or after October 1, 1988, and other diagnostic procedures performed on or after October 1, 1989.

SEC. 4067. UPDATING MAXIMUM RATE OF PAYMENT PER VISIT FOR INDEPENDENT RURAL HEALTH CLINICS.

(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is further amended by inserting after subsection (e) the following new subsection:

"(f) In establishing limits under subsection (a) on payment for rural health clinic services provided by independent rural health clinics, the Secretary shall establish such limit, for services provided—

"(1) in 1988, after March 31, at $46, and

"(2) in a subsequent year, at the limit established under this subsection for the previous year increased by the percentage increase in the medicare economic index (referred to in the fourth sentence of section 1842(b)(3)) applicable to physicians' services furnished as of the first day of that year.".

(b) REPORT ON RATES.—The Secretary of Health and Human Services shall report to Congress, by not later than March 1, 1989, on the adequacy of the amounts paid under title XVIII of the Social Security Act for rural health clinic services provided by independent rural health clinics.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after April 1, 1988.

SEC. 4068. PAYMENT FOR AMBULATORY SURGERY AT EYE, AND EYE AND EAR, SPECIALTY HOSPITALS.

(a) IN GENERAL.—Section 1833(i)(3)(B)(ii) of the Social Security Act (42 U.S.C. 1395l(i)(3)(B)(ii)) is amended—

(1) by striking "In" and inserting "Subject to the last sentence of this clause, in"; and

(2) by adding at the end thereof the following:

"In the case of a hospital that makes application to the Secretary and demonstrates that it specializes in eye services or eye and ear services (as determined by the Secretary), receives more than 30 percent of its total revenues from outpatient services and was an eye specialty hospital or an eye and ear specialty hospital on October 1, 1987, the cost proportion and ASC proportion in effect under subclauses (I) and (II) for cost reporting periods beginning in fiscal year 1988 shall remain in effect for cost reporting periods beginning in fiscal year 1989 or fiscal year 1990.".

(b) DEVELOPMENT OF PROSPECTIVE PAYMENT METHODOLOGY FOR OUTPATIENT HOSPITAL SERVICES.—Section 1135(d) of the Social Security Act (42 U.S.C. 1320b-5(d)) is amended—

(1) by adding at the end of paragraph (3) the following: "In establishing such rates, the Secretary shall consider whether a differential payment rate is appropriate for speciality hospitals."; and

(2) by adding at the end the following new paragraph:

"(7) The Secretary shall solicit the views of the Prospective Payment Assessment Commission in developing the systems under paragraphs (1) and (6), and shall include in the Secretary's reports under this subsection any views the Commission may submit with respect to such systems.".

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall be effective as if included in the amendment made by section 9343(a)(1)(B) of the Omnibus Budget Reconciliation Act of 1986.

Subpart C—Eligibility and Benefits Changes

SEC. 4070. COVERAGE OF MENTAL HEALTH SERVICES.

(a) OUTPATIENT SERVICES UNDER PART B.—Section 1833(c) of the Social Security Act (42 U.S.C. 1395l(c)) is amended—

(1) by striking "$312.50" and inserting "$1375.00"; and

(2) by adding at the end thereof the following:

"For purposes of this subsection, the term 'treatment' does not include brief office visits (as defined by the Secretary) for the sole purpose of prescribing or monitoring prescription drugs used in the treatment of such disorders.".

(b) PARTIAL HOSPITALIZATION COVERAGE.—

(1) Section 1861(s)(2)(B) of such Act (42 U.S.C. 1395x(s)(2)(B)) is amended by inserting "and partial hospitalization services incident to such services" before the semicolon.

(2) Section 1861 of such Act (42 U.S.C. 1395x) is amended by adding at the end thereof the following new subsection:

"(ff)(1) The term 'partial hospitalization services' means the items and services described in paragraph (2) prescribed by a physician and provided under a program described in paragraph (3) under the supervision of a physician pursuant to an individualized, written plan of treatment established and periodically reviewed by a physician (in consultation with appropriate staff participating in such program), which plan sets forth the physician's diagnosis, the type, amount, frequency, and duration of the items and services provided under the plan, and the goals for treatment under the plan.

"(2) The items and services described in this paragraph are—

"(A) individual and group therapy with physicians or psychologists (or other mental health professionals to the extent authorized under State law),

"(B) occupational therapy requiring the skills of a qualified occupational therapist,

"(C) services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients,

"(D) drugs and biologicals furnished for therapeutic purposes (which cannot, as determined in accordance with regulations, be self-administered),

"(E) individualized activity therapies that are not primarily recreational or diversionary,

"(F) family counseling (the primary purpose of which is treatment of the individual's condition),

"(G) patient training and education (to the extent that training and educational activities are closely and clearly related to individual's care and treatment),

"(H) diagnostic services, and

"(I) such other items and services as the Secretary may provide (but in no event to include meals and transportation);

that are reasonable and necessary for the diagnosis or active treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization, and furnished pursuant to such guidelines relating to frequency and duration of services as the Secretary shall by regulation establish (taking into account accepted norms of medical practice and the reasonable expectation of patient improvement).

"(3) A program described in this paragraph is a program which is hospital-based or hospital-affiliated (as defined by the Secretary) and which is a distinct and organized intensive ambulatory treatment service offering less than 24-hour-daily care.".

(3) Section 1835(a)(2) of such Act (42 U.S.C. 1395n(a)(2)) is amended—

(A) by striking "and" at the end of subparagraph (D);

(B) by striking the period at the end of subparagraph (E) and inserting "; and"; and

(C) by inserting after subparagraph (E) the following new subparagraph:

"(F) in the case of partial hospitalization services, (i) the individual would require inpatient psychiatric care in the absence of such services, (ii) an individualized, written plan for furnishing such services has been established by a physician and is reviewed periodically by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician.".

(4) Section 1833(c) of such Act, as amended by subsection (a), is further amended at the end thereof by inserting "or partial hospitalization services that are not directly provided by a physician" before the period.

(c) EFFECTIVE DATE; IMPLEMENTATION.—

(1) The amendment made by subsection (a)(1) shall apply with respect to calendar years beginning with 1988; except that with respect to 1988, any reference in section 1833(c) of the Social Security Act, as amended by subsection (a), to "$1375.00" is deemed a reference to "$562.50". The amendment made by subsection (a)(2) shall apply to services furnished on or after January 1, 1989.

(2)(A) The amendments made by subsection (b) shall become effective on the date of enactment of this Act.

(B) The Secretary of Health and Human Services shall implement the amendments made by subsection (b) so as to ensure that there is no additional cost to the medicare program by reason of such amendments.

SEC. 4071. COVERAGE OF INFLUENZA VACCINE AND ITS ADMINISTRATION.

(a) IN GENERAL.—Section 1861(s)(10)(A) of the Social Security Act (42 U.S.C. 1395x(a)(10)(A)) is amended by inserting before the semicolon the following: "and influenza vaccine and its administration".

(b) CONTINGENT EFFECTIVE DATE; DEMONSTRATION PROJECT.—

(1) The provisions of subsection (e) of section 4072 of this subpart shall apply to this section in the same manner as it applies to section 4072.

(2) In conducting the demonstration project pursuant to paragraph (1), in order to determine the cost effectiveness of including influenza vaccine in the medicare program, the Secretary of Health and Human Services is required to conduct a demonstration of the provision of influenza vaccine as a service for medicare beneficiaries and to expend $25,000,000 each year of the demonstration project for this purpose. In conducting this demonstration, the Secretary is authorized to purchase in bulk influenza vaccine and to distribute it in a manner to make it widely available to medicare beneficiaries, to develop projects to provide vaccine in the same manner as other covered medicare services in large scale demonstration projects, including statewide projects, and to engage in other appropriate use of moneys to provide influenza vaccine to medicare beneficiaries and evaluate the cost effectiveness of its use. In determining cost effectiveness, the Secretary shall consider the direct cost of the vaccine, the utilization of vaccine which might otherwise not have occurred, the costs of illnesses and nursing home days avoided, and other relevant factors, except that extended life for beneficiaries shall not be considered to reduce the cost effectiveness of the vaccine.

SEC. 4072. PAYMENT FOR THERAPEUTIC SHOES FOR INDIVIDUALS WITH SEVERE DIABETIC FOOT DISEASE.

(a) COVERAGE UNDER PART B.—Section 1861(s) of the Social Security Act (42 U.S.C. 1395x(s)) is amended—

(1) by redesignating paragraphs (12) through (15) as paragraphs (13) through (16), respectively,

(2) by striking out "and" at the end of paragraph (10),

(3) by striking out the period at the end of paragraph (11) and inserting "; and", and

(4) by inserting after paragraph (11) the following new paragraph:

"(12) extra-depth shoes with inserts or custom molded shoes for an individual with diabetes, if—

"(A) the physician who is managing the individual's diabetic condition (i) documents that the individual has peripheral neuropathy with evidence of callus formation, a history of pre-ulcerative calluses, a history of previous ulceration, foot deformity, or previous amputation, or poor circulation, and (ii) certifies that the individual needs such

shoes under a comprehensive plan of care related to the individual's diabetic condition;

"(B) the particular type of shoes are prescribed by a podiatrist or other qualified physician (as established by the Secretary); and

"(C) the shoes are fitted and furnished by a podiatrist or other qualified individual (such as a pedorthist or orthotist, as established by the Secretary) who is not the physician described in subparagraph (A) (unless the Secretary finds that the physician is the only such qualified individual in the area).".

(b) LIMITATION ON BENEFIT.—Section 1833 of such Act (42 U.S.C. 1395) is amended by inserting after subsection (e) the following new subsection:

"(f)(1) In the case of shoes described in section 1861(s)(12)—

"(A) no payment may be made under this part for the furnishing of more than one pair of shoes for any individual for any calendar year, and

"(B) with respect to expenses incurred in any calendar year, no more than the limit established under paragraph (2) shall be considered as incurred expenses for purposes of subsections (a) and (b).

Payment for shoes under this part shall be considered to include payment for any expenses for the fitting of such shoes.

"(2)(A) Except as provided by the Secretary under subparagraphs (B) and (C), the limit established under this paragraph—

"(i) for the furnishing of one pair of custom molded shoes is $300;

"(ii) for the furnishing of extra-depth shoes and inserts is—

"(I) $100 for the pair of shoes itself, and

"(II) $50 for inserts for a pair of shoes.

"(B) The Secretary or a carrier may establish limits for shoes that are lower than the limits established under subparagraph (A) if the Secretary finds that shoes and inserts of an appropriate quality are readily available at or below such lower limits.

"(C) For each year after 1988, each dollar amount under subparagraph (A) or (B) (as previously adjusted under this subparagraph) shall be increased by the same percentage increase as the Secretary provides with respect to durable medical equipment for that year, except that if such increase is not a multiple of $1, it shall be rounded to the nearest multiple of $1.

"(3) In this title, the term 'shoes' includes, except for purposes of subparagraphs (A)(ii) and (B) of paragraph (2), inserts for extra-depth shoes.".

(c) MODIFICATION OF EXCLUSION.—Section 1862(a)(8) of such Act (42 U.S.C. 1395y(a)(8)) is amended by inserting ", other than shoes furnished pursuant to section 1861(s)(12)" before the semicolon.

(d) CONFORMING AMENDMENTS.—Sections 1864(a), 1865(a), 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) of such Act (42 U.S.C. 1395aa(a), 1395bb(a), 1396a(a)(9)(C), 1396n(a)(1)(B)(ii)(I)) are each amended by striking out "paragraphs (12) and (13)" and inserting "paragraphs (13) and (14)".

(e) CONTINGENT EFFECTIVE DATE; DEMONSTRATION PROJECT.—

(1) The amendments made by this section shall become effective (if at all) in accordance with paragraph (2).

(2)(A) The Secretary of Health and Human Services (in this paragraph referred to as the "Secretary"), shall establish a demonstration project to begin on October 1, 1988, to test the cost-effectiveness of furnishing therapeutic shoes under the medicare program to the extent provided under the amendments made by this section to a sample group of medicare beneficiaries.

(B)(i) The demonstration project under subparagraph (A) shall be conducted for an initial period of 24 months. Not later than October 1, 1990, the Secretary shall report to the Congress on the results of such project. If the Secretary finds, on the basis of existing data, that furnishing therapeutic shoes under the medicare program to the extent provided under the amendments made by this section is cost-effective, the Secretary shall include such finding in such report, such project shall be discontinued, and the amendments made by this section shall become effective on November 1, 1990.

(ii) If the Secretary determines that such finding cannot be made on the basis of existing data, such project shall continue for an additional 24 months. Not later than April 1, 1993, the Secretary shall submit a final report to the Congress on the results of such project. The amendments made by this section shall become effective on the first day of the first month to begin after such report is submitted to the Congress unless the report contains a finding by the Secretary that furnishing therapeutic shoes under the medicare program to the extent provided under the amendments made by this section is not cost-effective (in which case the amendments made by this section shall not become effective).

SEC. 4073. COVERAGE OF CERTIFIED NURSE-MIDWIFE SERVICES.

(a) COVERAGE OF SERVICES.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) by striking "and" at the end of subparagraph (J);

(2) by adding "and" at the end of subparagraph (K); and

(3) by adding at the end thereof the following new subparagraph:

"(L) certified nurse-midwife services;".

(b) PAYMENT OF BENEFITS.—

(1) Section 1832(a)(2)(B) of such Act (42 U.S.C. 1395k(a)(2)(B)) is amended—

(A) by striking "and" at the end of clause (ii);

(B) by striking the semicolon at the end of clause (iii) and inserting a comma; and

(C) by adding at the end thereof the following new clause:

"(iv) certified nurse-midwife services; and".

(2) Section 1833(a)(1) of such Act (42 U.S.C. 1395k(a)(1)) is amended—

(A) by striking "and" at the end of clause (F);

(B) by striking "services; and" in clause (G) and inserting "services,"; and

(D) by adding at the end thereof the following: "and (I) with respect to certified nurse-midwife services under sec-

tion 1861(s)(2)(L), the amounts paid shall be the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph (but in no event more than 65 percent of the prevailing charge that would be allowed for the same service performed by a physician);".

(3) Section 1833 of such Act (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

"(m) In the case of certified nurse-midwife services for which payment may be made under this part only pursuant to section 1861(s)(2)(L), payment may only be made under this part for such services on an assignment-related basis.".

(c) DEFINITION.—Section 1861 of such Act (42 U.S.C. 1395x) is amended by adding at the end thereof the following new subsection:

"Certified Nurse-Midwife Services

"(ff)(1) The term 'certified nurse-midwife services' means such services furnished by a certified nurse-midwife (as defined in paragraph (2)) and such services and supplies furnished as an incident to his service which the certified nurse-midwife is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) as would otherwise be covered if furnished by a physician or as an incident to a physician's service.

"(2) The term 'certified nurse-midwife' means a registered nurse who has successfully completed a program of study and clinical experience meeting guidelines prescribed by the Secretary, or has been certified by an organization recognized by the Secretary, and performs services in the area of management of the care of mothers and babies throughout the maternity cycle.".

(c) CONFORMING CHANGES.—

(1) Section 1905(a)(17) of such Act (42 U.S.C. 1396d(a)(17)) is amended by striking "as defined in subsection (m)" and inserting "as defined in section 1861(ff)".

(2) Section 1905 of such Act (42 U.S.C. 1396d) is amended by striking subsection (m).

(d) EFFECTIVE DATE.—The amendments made by this section shall be effective with respect to services performed on or after July 1, 1988.

SEC. 4074. COVERAGE OF SOCIAL WORKER SERVICES FURNISHED BY A HEALTH MAINTENANCE ORGANIZATION TO ITS MEMBERS.

(a) IN GENERAL.—Section 1861(s)(2)(H)(ii) of the Social Security Act (42 U.S.C. 1395x(s)(2)(H)(ii)) is amended—

(1) by inserting "or by a clinical social worker (as defined in subsection (ff))" after "clinical psychologist (as defined by the Secretary)"; and

(2) by striking "incident to his services" and inserting "incident to such clinical psychologist's services or clinical social worker's services".

(b) CLINICAL SOCIAL WORKER DEFINED.—Section 1861 of such Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"Clinical Social Worker

"(ff) The term 'clinical social worker' means an individual who—

"(1) possesses a master's or doctor's degree in social work;

"(2) after obtaining such degree has performed at least 2 years of supervised clinical social work; and

"(3)(A) is licensed or certified as a clinical social worker by the State in which the services are performed, or

"(B) in the case of an individual in a State which does not provide for licensure or certification—

"(i) has completed at least 2 years or 3,000 hours of post-master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting (as determined by the Secretary), and

"(ii) meets such other criteria as the Secretary establishes.".

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective with respect to services performed on or after January 1, 1988.

SEC. 4075. CLARIFICATION OF COVERAGE OF DRUGS USED IN IMMUNOSUPPRESSIVE THERAPY.

(a) IN GENERAL.—Section 1861(s)(2)(J) of the Social Security Act (42 U.S.C. 1395x(s)(2)(J)) is amended by striking "immunosuppressive drugs" and inserting "prescription drugs used in immunosuppressive therapy".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to drugs dispensed on or after the date of the enactment of this Act.

SEC. 4076. SERVICES OF A PHYSICIAN ASSISTANT.

(a) SERVICES COVERED.—Section 1861(s)(2)(K) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)) is amended by inserting ", in a rural area (as defined in section 1886(d)(2)(D)) that is designated, under section 332(a)(1)(A) of the Public Health Service Act, as a health manpower shortage area," after "1905(c))".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished on or after January 1, 1989.

SEC. 4077. PSYCHOLOGIST SERVICES IN CLINICS.

(a) COVERAGE OF PSYCHOLOGISTS' SERVICES FURNISHED AT RURAL HEALTH CLINICS.—

(1) Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking "physician assistant or by a nurse practitioner" and inserting "physician assistant or a nurse practitioner (as defined in paragraph (3)), or by a clinical psychologist (as defined by the Secretary),".

(2) The amendment made by paragraph (1) shall be effective with respect to services furnished on or after the date of enactment of this Act.

(b) DIRECT PAYMENT FOR PSYCHOLOGISTS' SERVICES FURNISHED AT A COMMUNITY MENTAL HEALTH CENTER.—

(1) Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended, is amended—

(A) by striking "and" at the end of subparagraph (K);

(B) by adding "and" at the end of subparagraph (L); and

(C) by adding at the end thereof the following new subparagraph:

"(M) qualified psychologist services;".

(2) Section 1832(a)(2)(B) of such Act (42 U.S.C. 1395k(a)(2)(B)) is amended—

(A) by striking "and" at the end of clause (ii);

(B) by striking the semicolon in clause (iii) and inserting a comma; and

(C) by adding at the end thereof the following new clause:

"(iv) qualified psychologist services; and".

(3) Section 1833(a)(1) of such Act (42 U.S.C. 1395k(a)(1)) is amended—

(A) by striking "and" at the end of subparagraph (G);

(B) by striking "services; and" in subparagraph (H) and inserting "services,";

(C) by adding "and" at the end of subparagraph (I); and

(D) by adding at the end thereof the following new subparagraph: "(J) with respect to qualified psychologist services under section 1861(s)(2)(M), the amounts paid shall be the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph;".

(4) The subsection added by section 4073(b)(3) of this subpart is amended by inserting "and in the case of qualified psychologists services for which payment may be made under this part only pursuant to section 1861(s)(2)(M)" after "1861(s)(2)(L)".

(5) Section 1861 of such Act (42 U.S.C. 1395x) is amended by adding at the end thereof the following new subsection:

"Qualified Psychologist Services

"(gg) The term 'qualified psychologist services' means such services and such services and supplies furnished as an incident to his service furnished by a clinical psychologist (as defined by the Secretary) at a community mental health center (as such term is used in the Public Health Service Act) which the psychologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) as would otherwise be covered if furnished by a physician or as an incident to a physician's service.

(5) The amendments made by this subsection shall be effective with respect to services performed on or after July 1, 1988.

SEC. 4078. PROVISION OF OFFSITE COMPREHENSIVE OUTPATIENT REHABILITATION SERVICES.

Section 1861(cc)(1) of the Social Security Act (42 U.S.C. 1395x(cc)(1)) is amended by adding at the end thereof the following: "In the case of physical therapy, occupational therapy, and speech pathology services, there shall be no requirement that the item or service be furnished at any single fixed location if the item or service is furnished pursuant to such plan and payments are not otherwise made for the item or service under this title.".

SEC. 4079. DEMONSTRATION PROJECTS TO PROVIDE PAYMENT ON A PREPAID, CAPITATED BASIS FOR COMMUNITY NURSING AND AMBULATORY CARE FURNISHED TO MEDICARE BENEFICIARIES.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall enter into an agreement with not less than four eligible organizations submitting applications under this section to conduct demonstration projects to provide payment on a prepaid, capitated basis for community nurs-

ing and ambulatory care furnished to any individual entitled to benefits under part A and enrolled under part B of title XVIII of the Social Security Act (other than an individual medically determined to have end-stage renal disease) who resides in the geographic area served by the organization and enrolls with such organization (in accordance with subsection (c)(2)).

(b) DEFINITIONS OF COMMUNITY NURSING AND AMBULATORY CARE AND ELIGIBLE ORGANIZATION.—As used in this section:

(1) The term "community nursing and ambulatory care" means the following services:

(A) Part-time or intermittent nursing care furnished by or under the supervision of registered professional nurses.

(B) Physical, occupational, or speech therapy.

(C) Social and related services supportive of a plan of ambulatory care.

(D) Part-time or intermittent services of a home health aide.

(E) Medical supplies (other than drugs and biologicals) and durable medical equipment while under a plan of care.

(F) Medical and other health services described in paragraphs (2)(H)(ii) and (5) through (9) of section 1861(s) of the Social Security Act.

(G) Rural health clinic services described in section 1861(aa)(1)(C) of such Act.

(H) Certain other related services listed in section 1915(c)(4)(B) of such Act to the extent the Secretary finds such services are appropriate to prevent the need for institutionalization of a patient.

(2) The term "eligible organization" means a public or private entity, organized under the laws of any State, which meets the following requirements:

(A) The entity (or a division or part of such entity) is primarily engaged in the direct provision of community nursing and ambulatory care.

(B) The entity provides directly, or through arrangements with other qualified personnel, the services described in paragraph (1).

(C) The entity provides that all nursing care (including services of home health aids) is furnished by or under the supervision of a registered nurse.

(D) The entity provides that all services are furnished by qualified staff and are coordinated by a registered professional nurse.

(E) The entity has policies governing the furnishing of community nursing and ambulatory care that are developed by registered professional nurses in cooperation with (as appropriate) other professionals.

(F) The entity maintains clinical records on all patients.

(G) The entity has protocols and procedures to assure, when appropriate, timely referral to or consultation with other health care providers or professionals.

(H) The entity complies with applicable State and local laws governing the provision of community nursing and ambulatory care to patients.

(I) The requirements of subparagraphs (B), (D), and (E) of section 1876(b)(2) of the Social Security Act.

(c) AGREEMENTS WITH ELIGIBLE ORGANIZATIONS TO CONDUCT DEMONSTRATION PROJECTS.—

(1) The Secretary may not enter into an agreement with an eligible organization to conduct a demonstration project under this section unless the organization meets the requirements of this subsection and subsection (d) with respect to members enrolled with the organization under this section.

(2) The organization shall have an open enrollment period for the enrollment of individuals under this section. The duration of such period of enrollment and any other requirement pertaining to enrollment or termination of enrollment shall be specified in the agreement with the organization.

(3) The organization must provide to members enrolled with the organization under this section, through providers and other persons that meet the applicable requirements of titles XVIII and XIX of the Social Security Act, community nursing and ambulatory care (as defined in subsection (b)(1)) which is generally available to individuals residing in the geographic area served by the organization, except that the organization may provide such members with such additional health care services as the members may elect, at their option, to have covered.

(4) The organization must make community nursing and ambulatory care (and such other health care services as such individuals have contracted for) available and accessible to each individual enrolled with the organization under this section, within the area served by the organization, with reasonable promptness and in a manner which assures continuity.

(5) Section 1876(c)(5) of the Social Security Act shall apply to organizations under this section in the same manner as it applies to organizations under section 1876 of such Act.

(6) The organization must have arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for health care services it provides to such individuals under the demonstration project conducted under this section, which program (A) stresses health outcomes and (B) provides review by health care professionals of the process followed in the provision of such health care services.

(7) Under a demonstration project under this section—

(A) the Secretary could require the organization to provide financial or other assurances (including financial risk-sharing) that minimize the inappropriate substitution of other services under title XVIII of such Act for community nursing services; and

(B) if the Secretary determines that the organization has failed to perform in accordance with the requirements of the project (including meeting financial responsibility requirements under the project, any pattern of disproportionate or inappropriate institutionalization) the Secretary shall, after notice, terminate the project.

(d) DETERMINATION OF PER CAPITA PAYMENT RATES.—

(1) The Secretary shall determine for each 12-month period in which a demonstration project is conducted under this section, and shall announce (in a manner intended to provide notice to interested parties) not later than three months before the beginning of such period, with respect to each eligible organization conducting a demonstration project under this section, a per capita rate of payment for each class of individuals who are enrolled with such organization who are entitled to benefits under part A and enrolled under part B of title XVIII of the Social Security Act.

(2)(A) Except as provided in paragraph (3), the per capita rate of payment under paragraph (1) shall be determined in accordance with this paragraph.

(B) The Secretary shall define appropriate classes of members, based on age, disability status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

(C) The per capita rate of payment under paragraph (1) for each such class shall be equal to 95 percent of the adjusted average per capita cost (as defined in subparagraph (D)) for that class.

(D) For purposes of subparagraph (C), the term 'adjusted average per capita cost' means the average per capita amount that the Secretary estimates in advance (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in a geographic area served by an eligible organization or in a similar area, with appropriate adjustments to assure actuarial equivalence) would be payable in any contract year for those services covered under parts A and B of title XVIII of the Social Security Act and types of expenses otherwise reimbursable under such parts A and B which are described in subparagraphs (A) through (G) of subsection (b)(1) (including administrative costs incurred by organizations described in sections 1816 and 1842 of such Act), if the services were to be furnished by other than an eligible organization.

(3) The Secretary shall, in consultation with providers, health policy experts, and consumer groups develop capitation-based reimbursement rates for such classes of individuals entitled to benefits under part A and enrolled under part B of the Social Security Act as the Secretary shall determine. Such rates shall be applied in determining per capita rates of payment under paragraph (1) with respect to at least one eligible organization conducting a demonstration project under this section.

(4)(A) In the case of an eligible organization conducting a demonstration project under this section, the Secretary shall make monthly payments in advance and in accordance with the rate determined under paragraph (2) or (3), except as provided in subsection (e)(3)(B), to the organization for each individual enrolled with the organization.

(B) The amount of payment under paragraph (2) or (3) may be retroactively adjusted to take into account any difference be-

tween the actual number of individuals enrolled in the plan under this section and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

(5) The payment to an eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A and enrolled under part B of the Social Security Act shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under such Act in such proportions from each such trust fund as the Secretary deems to be fair and equitable taking into consideration benefits attributable to such parts A and B, respectively.

(6) During any period in which an individual is enrolled with an eligible organization conducting a demonstration project under this section, only the eligible organization (and no other individual or person) shall be entitled to receive payments from the Secretary under this title for community nursing and ambulatory care (as defined in subsection (b)(1)) furnished to the individual.

(e) RESTRICTION ON PREMIUMS, DEDUCTIBLES, COPAYMENTS, AND COINSURANCE.—

(1) In no case may the portion of an eligible organization's premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to community nursing and ambulatory care) to individuals who are enrolled under this section with the organization, exceed the actuarial value of the coinsurance and deductibles that would be applicable on the average to individuals enrolled under this section with the organization (or, if the Secretary finds that adequate data are not available to determine that actuarial value, the actuarial value of the coinsurance and deductibles applicable on the average to individuals in the area, in the State, or in the United States, eligible to enroll under this section with the organization, or other appropriate data) and entitled to benefits under part A and enrolled under part B of the Social Security Act, if they were not members of an eligible organization.

(2) If the eligible organization provides to its members enrolled under this section services in addition to community nursing and ambulatory care, election of coverage for such additional services shall be optional for such members and such organization shall furnish such members with information on the portion of its premium rate or other charges applicable to such additional services. In no case may the sum of—

(A) the portion of such organization's premium rate charged, with respect to such additional services, to members enrolled under this section, and

(B) the actuarial value of its deductibles, coinsurance, and copayments charged, with respect to such services to such members

exceed the adjusted community rate for such services (as defined in section 1876(e)(3) of the Social Security Act).

(3)(A) Subject to subparagraphs (B) and (C), each agreement to conduct a demonstration project under this section shall provide that if—

(i) the adjusted community rate, referred to in paragraph (2), for community nursing and ambulatory care covered under parts A and B of title XVIII of the Social Security Act (as reduced for the actuarial value of the coinsurance and deductibles under those parts) for members enrolled under this section with the organization,

is less than

(ii) the average of the per capita rates of payment to be made under subsection (d)(1) at the beginning of the 12-month period (as determined on such basis as the Secretary determines appropriate) described in such subsection for members enrolled under this section with the organization,

the eligible organization shall provide to such members the additional benefits described in section 1876(g)(3) of the Social Security Act which are selected by the eligible organization and which the Secretary finds are at least equal in value to the difference between that average per capita payment and the adjusted community rate (as so reduced).

(B) Subparagraph (A) shall not apply with respect to any organization which elects to receive a lesser payment to the extent that there is no longer a difference between the average per capita payment and adjusted community rate (as so reduced).

(C) An organization conducting a demonstration project under this section may provide (with the approval of the Secretary) that a part of the value of such additional benefits under subparagraph (A) be withheld and reserved by the Secretary as provided in section 1876(g)(5) of the Social Security Act.

(4) The provisions of paragraphs (3), (5), and (6) of section 1876(g) of the Social Security Act shall apply in the same manner to agreements under this section as they apply to risk-sharing contracts under section 1876 of such Act, and, for this purpose, any reference in such paragraphs to paragraph (2) is deemed a reference to paragraph (3) of this subsection.

(5) Section 1876(e)(4) of the Social Security Act shall apply to eligible organizations under this section in the same manner as it applies to eligible organizations under section 1876 of such Act.

(f) COMMENCEMENT AND DURATION OF PROJECTS.—Each demonstration project under this section shall begin not later than July 1, 1989, and shall be conducted for a period of three years.

(g) REPORT.—Not later than January 1, 1992, the Secretary shall submit to the Congress a report on the results of the demonstration projects conducted under this section.

SEC. 4080. PART B PREMIUM.

Section 1839 of the Social Security Act (42 U.S.C. 1395r) is amended—

(1) in subsection (e), by striking "1989" each place it appears and inserting in lieu thereof "1990";

(2) in subsection (f)(1), by striking "or 1987" and inserting in lieu thereof "1987, or 1988"; and

(3) in subsection (f)(2), by striking "or 1988" and inserting in lieu thereof "1988, or 1989".

Subpart D—Other Provisions

SEC. 4081. SUBMISSION OF CLAIMS TO SUPPLEMENTAL INSURANCE CARRIERS.

(a) IN GENERAL.—Section 1842(h)(3) of the Social Security Act (42 U.S.C. 1395u(h)(3)) is amended by inserting "(A)" after "(3)" and by adding at the end the following new subparagraph:

"(B) The Secretary shall establish a procedure whereby an individual enrolled under this part may assign, in an appropriate manner on the form claiming a benefit under this part for an item or service furnished by a participating physician or supplier, the individual's rights of payment under a medicare supplemental policy (described in section 1882(g)(1)) in which the individual is enrolled. In the case such an assignment is properly executed and a claims determination is made by a carrier with a contract under this section, the carrier shall transmit to the private entity issuing the medicare supplemental policy notice of such fact and including such information as the Secretary determines is generally provided to enable the entity to decide whether (and the amount of) any payment is due under the policy. The Secretary may enter into arrangements for the transmittal of such information to entities electronically. The Secretary shall impose user fees for the transmittal of information under this subparagraph, whether electronically or otherwise.".

(b) MEDIGAP POLICY STANDARDS.—Section 1882 of such Act (42 U.S.C. 1395ss) is amended—

(1) in subsection (b)(1)—

(A) by amending subparagraph (B) to read as follows:

"(B) includes requirements equal to or more stringent than the requirements described in paragraphs (2) and (3) of subsection (c);",

(B) by adding "and" at the end of subparagraph (C), and

(C) by inserting after subparagraph (C) the following new subparagraph:

"(D) provides the Secretary periodically (but at least annually) with a list containing the name and address of the issuer of each such policy and the name and number of each such policy (including an indication of policies that have been previously approved, newly approved, or withdrawn from approval since the previous list was provided),";

(2) in subsection (c)—

(A) by striking "and" at the end of paragraph (1),

(B) by striking the period at the end of paragraph (2) and inserting "; and", and

(C) by inserting after paragraph (2) the following new paragraph:

"(3)(A) accepts a notice under section 1842(h)(3)(B) as a claims form for benefits under such policy in lieu of any claims form otherwise required and agrees to make a payment determination on the basis of the information contained in such claims form;

"(B) where such a notice is received—

"(i) provides notice to such physician or supplier and the beneficiary of the payment determination, and

"(ii) provides any appropriate payment directly to the participating physician or supplier involved;

"(C) provides each enrollee at the time of enrollment a card listing the policy name and number and a single mailing address to which notices under section 1842(h)(3)(B) respecting the policy are to be sent;

"(D) agrees to pay any user fees established under section 1842(h)(3)(B) with respect to information transmitted to the issuer of the policy; and

"(E) provides to the Secretary at least annually, for transmittal to carriers, a single mailing address to which notices under section 1842(h)(3)(B) respecting the policy are to be sent.".

(c) EFFECTIVE DATES.—(1) The amendment made by subsection (a) shall apply to contracts with carriers for claims for items and services furnished by participating physicians and suppliers on or after January 1, 1989.

(2)(A) The amendments made by subsection (b) shall apply to medicare supplemental policies as of January 1, 1989 (or, if applicable, the date established under subparagraph (B)).

(B) In the case of a State which the Secretary of Health and Human Services identifies as—

(i) requiring State legislation (other than legislation appropriating funds) in order for medical supplemental policies to be changed to meet the requirements of section 1882(c)(3) of the Social Security Act, and

(ii) having a legislature which is not scheduled to meet in 1988 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1989, and in which legislation described in clause (i) may be considered.

SEC. 4082. REVISION OF PART B HEARINGS.

(a) CLARIFICATION OF OBRA AMENDMENT.—Section 1869(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ff(b)(3)(B)) is amended by striking "chapter 5" and inserting "section 553".

(b) EXPEDITED ADMINISTRATIVE HEARING WHERE ONLY ISSUES OF LAW.—Section 1869(b) of such Act (42 U.S.C. 1395ff(b)) is amended by adding at the end the following new paragraph:

"(5) In an administrative hearing pursuant to paragraph (1), where the moving party alleges that there are no material issues of fact in dispute, the administrative law judge shall make an expedited determination as to whether any such facts are in dispute and, if not, shall determine the case expeditiously.".

(c) TIMELY CARRIER HEARINGS ON PART B APPEALS.—Section 1842(b)(5) of such Act (42 U.S.C. 1395u(b)(5)) is amended—

(1) by inserting "(A)" after "(5)", and

(2) by adding at the end the following new subparagraph:

"(B) The Secretary shall establish standards for evaluating carriers' performance of reviews of initial carrier determinations and of

fair hearings under paragraph (3)(C), under which a carrier is expected—

"(i) to complete such reviews, within 45 days after the date of a request by an individual enrolled under this part for such a review, in 95 percent of such requests, and

"(ii) to make a final determination, within 120 days after the date of receipt of a request by an individual enrolled under this part for a fair hearing under paragraph (3)(C), in 90 percent of such cases.".

(d) GAO STUDY.—The Comptroller General shall conduct a study concerning the cost effectiveness of requiring hearings with a carrier under part B of title XVIII of the Social Security Act before having a hearing before an administrative law judge respecting carrier determinations under that part. The Comptroller General shall report to the Congress on the results of such study by not later than June 30, 1989.

(e) EFFECTIVE DATES.—(1) The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

(2) The amendment made by subsection (b) shall apply to requests for hearings filed after the end of the 60-day period beginning on the date of the enactment of this Act.

(3) The amendments made by subsection (c) shall apply to evaluation of performance of carriers under contracts entered into or renewed on or after October 1, 1988.

SEC. 4083. PROVISIONS RELATING TO PHYSICIAN PAYMENT REVIEW COMMISSION.

(a) REVISION OF APPOINTMENT PROCESS FOR THE PHYSICIAN PAYMENT REVIEW COMMISSION.—

(1) IN GENERAL.—Section 1845(a) of Social Security Act (42 U.S.C. 1395w-1(a)(3)) is amended—

(A) in paragraph (1), by striking "with expertise in the provision and financing of physicians' services" and inserting "with national recognition for their expertise in health economics, physician reimbursement, medical practice, and other related fields"; and

(B) in paragraph (3), by striking the last sentence.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to appointments made after the date of the enactment of this Act.

(b) TREATMENT OF EMPLOYEES FOR CERTAIN PURPOSES.—

(1) IN GENERAL.—Section 1886(e)(6)(D) of the Social Security Act (42 U.S.C. 1395ww(e)(6)(D)) is amended by adding at the end the following: "For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on the date of the enactment of this Act.

(c) CHANGE IN DATE FOR ANNUAL REPORT OF PHYSICIAN PAYMENT REVIEW COMMISSION.—

(1) Section 1845(b)(1) of such Act (42 U.S.C. 1395w-1(b)(1)) is amended by striking "March 1" and inserting "March 31".

(2) The amendment made by paragraph (1) shall apply with respect to reports for years after 1987.

SEC. 4084. TECHNICAL AMENDMENTS RELATED TO CERTIFIED REGISTERED NURSE ANESTHETISTS.

(a) IN GENERAL.—Section 1833(l) of the Social Security Act (42 U.S.C. 1395l(l)), as added by section 9320(e) of the Omnibus Budget Reconciliation Act of 1986, is amended—

(1) in paragraph (2), by striking "1985" and inserting "1985 and such other data as the Secretary determines necessary"; and

(2) in paragraph (5)(A), by striking "or group practice" each place it appears and inserting "group practice, or ambulatory surgical center".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply as if included in the amendment made by section 9320(e)(2) of the Omnibus Budget Reconciliation Act of 1986.

SEC. 4085. MISCELLANEOUS AND TECHNICAL PROVISIONS.

(a) PROMPT SUBMITTAL OF DATA BY SECRETARY.—Section 1845 of the Social Security Act (42 U.S.C. 1395w-1) is amended by adding at the end the following new subsection:

"(f)(1) Not later than October 1st of each year (beginning with 1988), the Secretary shall transmit to the Physician Payment Review Commission, to the Congressional Budget Office, and to the Congressional Research Service of the Library of Congress national data (known as the Part B Medicare Annual Data System) for the previous year respecting part B of this title.

"(2) In order to ensure that the data are available for transmittal under paragraph (1) on a timely basis, the Secretary shall require, in the standards and criteria established under section 1842(b)(2), that carriers submit data for a year under the system referred to in paragraph (1) not later than July 1st of the following year.

"(3) The Secretary, in consultation with the Physician Payment Review Commission, the Congressional Budget Office, and the Congressional Research Service of the Library of Congress, shall establish and annually revise standards for the data reporting system described in paragraph (1).

"(4) The Secretary shall also provide to the entities described in paragraph (1) additional data respecting the program under this part as may be reasonably requested by them on an agreed-upon schedule.

"(5) The Secretary shall develop, in consultation with the Physician Payment Review Commission, the Congressional Budget Office, and the Congressional Research Service of the Library of Congress, a system for providing to each of such entities on a quarterly basis summary data on aggregate expenditures under this part by type of service and by type of provider. Such data shall be provided not later than 90 days after the end of each quarter (for quarters beginning with the calendar quarter ending on March 31, 1989).".

(b) CLARIFICATION OF PENALTIES FOR UNASSIGNED LABORATORY SERVICES.—

(1) IN GENERAL.—Section 1833(h)(5) of the Social Security Act (42 U.S.C. 1395l(h)(5)) is amended by adding at the end the following new subparagraph:

"(D) If a person knowingly and willfully and on a repeated basis bills an individual enrolled under this part for charges for a clinical diagnostic laboratory test for which payment may only be made on an assignment-related basis under subparagraph (C), the Secretary may apply sanctions against the person in the same manner as the Secretary may apply sanctions against a physician in accordance with section 1842(j)(2).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to procedures performed on or after January 1, 1988.

(c) EXTENSION OF MORATORIUM ON LABORATORY PAYMENT DEMONSTRATION.—Section 9204(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended by section 9339(e) of the Omnibus Budget Reconciliation Act of 1986, is amended by striking "January 1, 1988" and inserting "January 1, 1989".

(d) PROMPT PAYMENT FOR COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES.—

(1) Section 1816(c)(2)(C) of the Social Security Act (42 U.S.C. 1395h(c)(2)(C)) is amended by striking "or hospice program" and inserting "hospice program, comprehensive outpatient rehabilitation facility, or rehabilitation agency".

(2)(A) The amendment made by paragraph (1) shall apply to claims received on or after the date of enactment of this Act.

(B) The Secretary of Health and Human Services shall provide for such timely amendments to agreements under section 1816, and regulations, to such extent as may be necessary to implement the amendment made by paragraph (1).

(e) CAPACITY TO SET GEOGRAPHIC PAYMENT LIMITS.—The Secretary of Health and Human Services shall develop the capability to implement (for services furnished on or after January 1, 1989) geographic limits on charges and payments under part B of title XVIII of the Social Security Act for physicians' services based on statewide, regional, or national average (or percentile in a distribution) of prevailing charges or payment amounts (weighted by frequency of services). Any such limits shall take into account adjustments for geographic differences in cost of practice and cost of living.

(f) DELAY IN EFFECTIVE DATE FOR ESTABLISHING PHYSICIAN IDENTIFIER SYSTEM.—Section 9202(g) of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking "July 1, 1987" and inserting "October 1, 1988".

(g) DATE FOR APPLYING CIVIL PENALITIES FOR IMPROPER USE OF ASSISTANTS IN PERFORMING CATARACT SURGERY.—

(1) Section 1842(k) of the Social Security Act (42 U.S.C. 1395u(k)) is amended in paragraphs (1) and (2) by striking "(j)(2)" each place it appears and inserting "(j)(2) in the case of surgery performed on or after March 1, 1987".

(2) The amendment made by paragraph (1) shall be effective as if included in section 9307(c) of the Consolidated Omnibus Budget Reconciliation Act of 1985.

(h) UTILIZATION SCREENS FOR PHYSICIAN SERVICES PROVIDED TO PATIENTS IN REHABILITATION HOSPITALS.—

(1) The Secretary of Health and Human Services shall establish (in consultation with appropriate physician groups, including those representing rehabilitative medicine) a separate utilization screen for physician visits to patients in rehabilitation

hospitals and rehabilitative units (and patients in long-term care hospitals receiving rehabilitation services) to be used by carriers under section 1842 of the Social Security Act in performing functions under subsection (a) of such section related to the utilization practices of physicians in such hospitals and units.

(2) Not later than 12 months after the date of enactment of this Act, the Secretary of Health and Human Services shall take appropriate steps to implement the utilization screen established under paragraph (1).

(i) TECHNICAL AMENDMENTS.—

(1) Section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)) is amended—

(A) in paragraphs (1)(D)(i) and (2)(D)(i), by striking, "on the basis of an assignment described in section 1842(b)(3)(B)(ii), under the procedure described in section 1870(f)(1)," and inserting "on an assignment-related basis";

(B) in paragraph (1), by striking "and" before "(G)"; and

(C) in subsection (b)(3)(A), by striking "on the basis of an assignment described in section 1842(b)(3)(B)(ii), under the procedure described in section 1870(f)(1)" and inserting "on an assignment-related basis".

(2) Section 1833(h)(1)(C) of such Act (42 U.S.C. 1395l(h)(1)(C)) is amended by inserting before the period the following: ", and ending on December 31, 1989. For such tests furnished on or after January 1, 1990, the fee schedule shall be established on a nationwide basis".

(3) Section 1833(h)(5)(A) of such Act (42 U.S.C. 1395l(h)(5)(A)) is amended by striking "and" at the end of clause (i), by striking the period at the end of clause (ii) and inserting ", and", and by adding at the end the following new clause:

"(iii) in the case of a clinical diagnostic laboratory test provided under an arrangement (as defined in section 1861(w)(1)) made by a hospital, payment shall be made to the hospital.".

(4) Section 1835(a)(2)(C) of such Act (42 U.S.C. 1395n(a)(2)(C)) is amended by striking the second comma at the end of clause (i).

(5) Section 1842(b)(3)(C) of such Act (42 U.S.C. 1395u(b)(3)(C)) is amended by striking "not more than" and inserting "less than".

(6) Section 1842(h)(5) of such Act (42 U.S.C. 1395u(h)(5)) is amended by striking "the" before "participation".

(7) Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986, section 1842(j)(1) of the Social Security Act (42 U.S.C. 1395u(j)(1)) is amended—

(A) in subparagraph (C)(i), by inserting "maximum allowable" after "If the physician's",

(B) in subparagraph (C)(v), by striking "1987" and insert "1986", and

(C) by adding at the end of subparagraph (C) the following new clause:

"(vii) In the case of a nonparticipating physician who was a participating physician during a previous period, for the purpose of computing the physician's maximum allowable actual charge

during the physician's period of nonparticipation, the physician shall be deemed to have had a maximum allowable actual charge during the period of participation, and such deemed maximum allowable actual charge shall be determined accordingly to clauses (i) through (vi).".

(8) Paragraph (4) of section 1845(e) of the Social Security Act (42 U.S.C. 1395w-1(e)) is amended by moving the alignment of each of its provisions (including any clauses therein) 2 ems to the left.

(9) Section 1861(b)(4) of such Act (42 U.S.C. 1395x(b)(4)) is amended by striking the comma before "anesthesia" and inserting "and" and by striking "certified" the second place it appears.

(10) The heading of subsection (g) of section 1861 of such Act (42 U.S.C. 1395x) is amended to read as follows:

"Outpatient Occupational Therapy Services".

(11) Section 1861(s) of such Act (42 U.S.C. 1395x(s)), as amended by section 9367(a) of this Act, is amended by striking "which—" before paragraph (15) and all that follows through the end of paragraph (16) and inserting the following: "which would not be included under subsection (b) if it were furnished to an inpatient of a hospital.".

(12) Section 1861(v)(5)(A) of such Act (42 U.S.C. 1395x(v)(5)(A)) is amended by striking "section 1861(p)" and "section 1861(g)" and inserting "subsection (p)" and "subsection (g)", respectively.

(13) The heading of subsection (bb) of section 1861 of such Act (42 U.S.C. 1395x) is amended to read as follows:

"Services of a Certified Registered Nurse Anesthetist".

(14) The heading of subsection (ee) of section 1861 of such Act (42 U.S.C. 1395x) is amended to read as follows:

"Discharge Planning Process".

(15) Section 1862(a)(1)(A) of such Act (42 U.S.C. 1395y(a)(1)(A)) is amended by striking "or (D)" and inserting "(D), or (E)".

(16) Section 1862(a)(14) of such Act (42 U.S.C. 1395y(a)(14)) is amended by striking "an patient" and inserting "a patient".

(17) Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986, section 1866(g) of the Social Security Act (42 U.S.C. 1395cc(g)) is amended by striking "for a hospital outpatient service" and all that follows through "subsection (a)(1)(H)" and inserting "inconsistent with an arrangement under subsection (a)(1)(H) or in violation of the requirement for such an arrangement".

(18) Section 1869(a) of the Social Security Act (42 U.S.C. 1395ff(a)) is amended by inserting "or a claim for benefits with respect to home health services under part B" before "shall".

(19) Section 1869(b)(2) of such Act (42 U.S.C. 1395ff(b)(2)) is amended by inserting "and (1)(D)" after "paragraph (1)(C)" each place it appears.

(20) Section 1875(c)(3)(B) of such Act (42 U.S.C. 1395ll(c)(3)(B)) is amended by striking "years 1987" and inserting "year 1987".

(21) Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986—

(A) section 9313(d)(3) of such Act is amended by striking "2 years after the date of the enactment of this Act" and inserting "January 1, 1990";

(B) section 9332(a)(3) of such Act is amended by inserting before the period at the end the following: "or in increasing the proportion of total payments for physicians' services which are payments for such services rendered by participating physicians";

(C) section 9335(j)(2) of such Act is amended by inserting before the period at the end the following: "except that, until network administrative organizations are established under section 1881(c)(1)(A) of the Social Security Act (as amended by subsection (d)(1) of this section), the distribution of payments described in the last sentence of section 1881(b)(7) of such Act shall be made based on the distribution of payments under section 1881 of such Act to network administrative organizations for fiscal year 1986"; and

(D) section 9343 of such Act is amended—

(i) amending subparagraph (A) of subsection (e)(2) to read as follows:

"(2)(A) Section 1833 (42 U.S.C. 1395l) is amended—

"(i) in subsection (a)(1)(F), by striking '(i)(3)' and inserting '(i)(4)', and

"(ii) in subsection (b)(3), by striking 'or under subsection (i)(2) or (i)(4)'.";

(ii) in subsection (h)(2), by striking "(d)" and inserting "(c)" and by adding at the end the following: "The amendments made by subsection (c) shall apply to services furnished after June 30, 1987."; and

(iii) in subsection (h)(4), by striking "(c)" and inserting "(d)".

PART 4—PEER REVIEW ORGANIZATIONS

SEC. 4091. CONTRACT PROVISIONS.

(a) EXTENSIONS OF PEER REVIEW CONTRACT PERIOD.—

(1) ONE-TIME EXTENSIONS TO PERMIT STAGGERING OF EXPIRATION DATES.—

(A) IN GENERAL.—In order to permit the Secretary of Health and Human Services an adequate time to complete contract renewal negotiations with utilization and quality control peer review organizations under part B of title XI of the Social Security Act and to provide for a staggered period of contract expiration dates, notwithstanding section 1153(c) of such Act, the Secretary may provide for extensions of existing contracts, but the total of such extensions may not exceed 24 months for any contract.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply to renewals occurring on or after the date of the enactment of this Act.

(2) 3-YEAR CONTRACT PERIOD.—

(A) Section 1153(c)(3) of such Act (42 U.S.C. 1320c-2(c)(3)) is amended by striking "two" and "biennial" and inserting "three" and "triennial", respectively.

(B) The amendment made by subparagraph (A) shall apply with respect to contracts entered into or renewed on or after the date of the enactment of this Act.

(b) CONTRACT REQUIREMENTS.—

(1) Section 1153 of the Social Security Act (42 U.S.C. 1320c–2) is amended by adding at the end the following new subsection:

"(h)(1) The Secretary shall publish in the Federal Register any new policy or procedure adopted by the Secretary that affects substantially the performance of contract obligations under this section not less than 30 days before the date on which such policy or procedure is to take effect. This paragraph shall not apply to the extent it is inconsistent with a statutory deadline.

"(2) The Secretary shall publish in the Federal Register the general criteria and standards used for evaluating the efficient and effective performance of contract obligations under this section and shall provide opportunity for public comment with respect to such criteria and standards.

"(3) The Secretary shall regularly furnish each peer review organization with a contract under this section with a report that documents the performance of the organization in relation to the performance of other such organizations.".

(2) Section 1153(e) of such Act (42 U.S.C. 1320c–2(e)) is amended—

(A) by inserting "(1)" after "(e)";

(B) by striking "Contracting" and inserting "Except as provided in paragraph (2), contracting"; and

(C) by adding at the end the following new paragraph:

"(2) If a peer review organization with a contract under this section is required to carry out a review function in addition to any function required to be carried out at the time the Secretary entered into or renewed the contract with the organization, the Secretary shall, before requiring such organization to carry out such additional function, negotiate the necessary contractual modifications, including modifications that provide for an appropriate adjustment (in light of the cost of such additional function) to the amount of reimbursement made to the organization.".

(3) The amendments made by paragraphs (1) and (2) shall become effective on the date of enactment of this Act.

SEC. 4092. PREFERENCE IN CONTRACTING WITH IN-STATE ORGANIZATIONS.

(a) IN GENERAL.—Section 1153 of the Social Security Act (42 U.S.C. 1320c–2), as amended by section 4091(b)(1) of this part, is further amended by adding at the end the following new subsection:

"(i)(1) Notwithstanding any other provision of this section, the Secretary shall not renew a contract with any organization that is not an in-State organization (as defined in paragraph (3)) unless the Secretary has first complied with the requirements of paragraph (2).

"(2)(A) Not later than six months before the date on which a contract period ends with respect to an organization that is not an in-State organization, the Secretary shall publish in the Federal Register—

"(i) the date on which such period ends; and

"(ii) the period of time in which an in-State organization may submit a proposal for the contract ending on such date.

"(B) If one or more qualified in-State organizations submits a proposal within the period of time specified under subparagraph (A)(ii), the Secretary shall not automatically renew the current contract on a noncompetitive basis, but shall provide for competition for the contract in the same manner as a new contract under subsection (b).

"(3) For purposes of this subsection, an in-State organization is an organization that has its primary place of business in the State in which review will be conducted (or, which is owned by a parent corporation the headquarters of which is located in such State).".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to contracts scheduled to be renewed on or after the first day of the eighth month to begin after the date of enactment of this Act.

SEC. 4093. REQUIRING REASONABLE NOTICE AND OPPORTUNITY FOR DISCUSSION PRIOR TO DENIAL OF CLAIM.

(a) IN GENERAL.—Section 1154(a)(3) of the Social Security Act (42 U.S.C. 1320c-3(a)(3)) is amended to read as follows:

"(3)(A) Subject to subparagraph (B), whenever the organization makes a determination that any health care services or items furnished or to be furnished to a patient by any practitioner or provider are disapproved, the organization shall promptly notify such patient and the agency or organization responsible for the payment of claims under title XVIII of this Act of such determination.

"(B) The notification under subparagraph (A) shall not occur until 20 days after the date that the organization has—

"(i) made a preliminary notification to such practitioner or provider of such proposed determination, and

"(ii) provided such practitioner or provider an opportunity for discussion and review of the proposed determination.

The discussion and review conducted under subparagraph (B)(ii) shall not affect the rights of a practitioner or provider to a formal reconsideration of a determination under this part (as provided under section 1155).".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to determinations made on or after April 1, 1988.

SEC. 4094. PEER REVIEW NORMS AND EDUCATION.

(a) STANDARDS APPLIED BY PROs.—Section 1154(a)(6) of the Social Security Act (42 U.S.C. 1320c-3(a)(6)) is amended by adding after and below subparagraph (B) thereof the following:

"As a component of the norms described in clause (i) or (ii), the organization shall take into account the special problems associated with delivering care in remote rural areas, the availability of service alternatives to inpatient hospitalization, and other appropriate factors (such as the distance from a patient's resi-

dence to the site of care, family support, availability of proximate alternative sites of care, and the patient's ability to carry out necessary or prescribed self-care regimens) that could adversely affect the safety or effectiveness of treatment provided on an outpatient basis.".

(b) ON-SITE REVIEW.—Section 1154(a) of such Act (42 U.S.C. 1320c-3(a)) is amended by adding at the end the following new paragraph:

"(15) During each year of the contract entered into under section 1153(b), the organization shall perform significant on-site review activities, including on-site review at at least 20 percent of the rural hospitals in the organization's area.".

(c) REPORTS TO PROVIDERS AND EDUCATIONAL ACTIVITIES.—

(1)(A) Section 1154(a)(6) such Act (42 U.S.C. 1320c-3(a)(6)) is amended—

(i) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively,

(ii) by inserting "(A)" after "(6)", and

(iii) by adding at the end the following:

"(B) The organization shall—

"(i) offer to provide, several times each year, for a physician representing the organization to meet (at a hospital or at a regional meeting) with medical and administrative staff of each hospital (the services of which are reviewed by the organization) respecting the organization's review of the hospital's services for which payment may be made under title XVIII, and

"(ii) publish (not less often than annually) and distribute to providers and practitioners whose services are subject to review a report that describes the organization's findings with respect to the types of cases in which the organization has frequently determined that (I) inappropriate or unnecessary care has been provided, (II) services were rendered in an inappropriate setting, or (III) services did not meet professionally recognized standards of health care.".

(B) The amendments made by subparagraph (A) shall apply to contracts under part B of title XI of the Social Security Act entered into or renewed more than 6 months after the date of the enactment of this Act.

(2)(A) Section 1154(a)(4)(B) of the Social Security Act (42 U.S.C. 1320c-3(a)(4)(B)) is amended—

(i) by inserting before the period at the end of the first sentence the following: "and whether individuals enrolled with an eligible organization have adequate access to health care services provided by or through such organization (as determined, in part, by a survey of individuals enrolled with the organization who have not yet used the organization to receive such services). The contract of each organization shall also provide that with respect to health care provided by a health maintenance organization or competitive medical plan under section 1876, the organization shall maintain a beneficiary outreach program designed to apprise individuals receiving care under such section of the role of the peer review system, of the rights of

the individual under such system, and of the method and purposes for contacting the organization"; and

(ii) by striking "previous sentence" and inserting "previous two sentences".

(B) Section 1154(a)(7)(A) of such Act (42 U.S.C. 1320c-3(a)(7)(A)) is amended—

(i) by inserting "(i)" after "(A)",

(ii) by striking the semicolon and inserting "; and", and

(iii) by adding at the end thereof the following new clause:

"(ii) in the case of psychiatric and physical rehabilitation services, make arrangements to ensure that (to the extent possible) initial review of such services be made by a physician who is trained in psychiatry or physical rehabilitation (as appropriate).".

(C) The amendments made by this paragraph shall apply with respect to contracts entered into or renewed on or after the date of enactment of this Act.

(d) PEER REVIEW EMPHASIS ON EDUCATIONAL ACTIVITIES. —

(1) Section 1153(c) of such Act (42 U.S.C. 1320c-2(c)) is amended by adding after and below paragraph (8) the following: "In evaluating the performance of utilization and quality control peer review organizations under contracts under this part, the Secretary shall place emphasis on the performance of such organizations in educating providers and practitioners (particularly those in rural areas) concerning the review process and criteria being applied by the organization.".

(2) The amendment made by paragraph (1) shall apply to contracts under part B of title XI of the Social Security Act as of January 1, 1988.

(e) TELECOMMUNICATIONS DEMONSTRATION PROJECTS.—The Secretary of Health and Human Services shall enter into agreements with entities submitting applications under this subsection (in such form as the Secretary may provide) to establish demonstration projects to examine the feasability of requiring instruction and oversight of rural physicians, in lieu of imposing sanctions, through use of video communication between rural hospitals and teaching hospitals under this title. Under such demonstration projects, the Secretary may provide for payments to physicians consulted via video communication systems. No funds may be expended under the demonstration projects for the acquisition of capital items including computer hardware.

SEC. 4095. PREEXCLUSION HEARINGS.

(a) IN GENERAL.—Section 1156(b) of the Social Security Act (42 U.S.C. 1320c-5(b)) is amended by adding at the end the following new paragraph:

"(5) Before the Secretary may effect an exclusion under paragraph (2) in the case of a provider or practitioner located in a rural health manpower shortage area (HMSA) or in a county with a population of less than 70,000, the provider or practitioner adversely affected by the determination is entitled to a hearing before an administrative law judge (described in section 205(b)) respecting whether the provider or practitioner should be able to continue furnishing services

to individuals entitled to benefits under this Act, pending completion of the administrative review procedure under paragraph (4). If the judge does not determine, by a preponderance of the evidence, that the provider or practitioner will pose a serious risk to such individuals if permitted to continue furnishing such services, the Secretary shall not effect the exclusion under paragraph (2) until the provider or practitioner has been provided reasonable notice and opportunity for an administrative hearing thereon under paragraph (4).".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to determinations made by the Secretary of Health and Human Services under section 1156(b) of the Social Security Act on or after the date of the enactment of this Act.

(c) TRANSITION FOR CURRENT CASES.—In the case of a practitioner or person—

(1) for whom a notice of determination under section 1156(b) of the Social Security Act has been provided within 365 days before the date of the enactment of this Act,

(2) who has not exhausted the administrative remedies available under section 1156(b)(4) of such Act for review of the determination, and

(3) who requests, within 90 days after the date of the enactment of this Act, a hearing established under this subsection, the Secretary of Health and Human Services shall provide for a hearing described in section 1156(b)(5) of the Social Security Act (as amended by subsection (a) of this section).

(d) REDETERMINATIONS IN CERTAIN CASES.—If, in hearing under subsection (c), the judge does not determine, by a preponderance of the evidence, that the provider or practitioner will pose a serious risk to individuals entitled to benefits under title XVIII of the Social Security Act if permitted to continue or resume furnishing such services, the Secretary shall not effect the exclusion (or shall suspend the exclusion, if previously effected) under paragraph (2) of section 1156(b) of such Act until the provider or practitioner has been provided an administrative hearing thereon under paragraph (4) of such section, notwithstanding any failure by the provider or practitioner to request the hearing on a timely basis.

(e) REPORT ON IMPROVEMENTS IN PROCEDURES FOR IMPOSING SANCTIONS.—Not later than one year after the date of enactment of this Act, the Secretary of Health and Human Services shall report to Congress on the improved procedures for imposing sanctions against a practitioner or person under section 1156 of the Social Security Act established through agreement by the Health Care Financing Administration, the American Association of Retired Persons, the American Medical Association, and the Office of the Inspector General in the Department of Health and Human Services. The report shall set forth such improved procedures, describe the response of physicians and providers to the procedures, assess whether the procedures effect an appropriate balance between procedural fairness and the need for ensuring quality medical care, comment on the alternative provider-patient notification procedure contained in the agreement, and recommend whether such procedures should apply to institutional providers of health care services.

SEC. 4096. LIMITATION OF BENEFICIARY LIABILITY FOR SERVICES DISALLOWED BY PEER REVIEW ORGANIZATIONS.

(a) PART B SERVICES.—

(1) Section 1842 of the Social Security Act (42 U.S.C 1395u) is amended—

(A) in subsection (b)(3)(ii), by inserting "(and to refund amounts already collected)" after "agrees not to charge", and by striking "and (II)" and inserting ", (II) the physician or other person furnishing such service agrees not to charge (and to refund amounts already collected) for services for which payment under this title is denied under section 1154(a)(2) by reason of a determination under section 1154(a)(1)(B), and (III)";

(B) in subsection (l)(1)(A)(iii), by inserting "(I)" after "(iii)" and by inserting before the comma the following: "or (II) payment under this title for such services is denied under section 1154(a)(2) by reason of a determination under section 1154(a)(1)(B)"; and

(C) in subsection (l)(1)(C), by inserting "in the case described in subparagraph (A)(iii)(I)" after "to an individual".

(2) Section 1870(f) of such Act (42 U.S.C. 1395gg(f)) is amended by striking "that the reasonable charge is the full charge for the services" each place it appears and inserting "to the terms specified in subclauses (I) and (II) of section 1842(b)(3)(B)(ii) with respect to the services".

(b) INDEMNIFICATION.—Section 1879(b) of such Act (42 U.S.C. 1395pp(b)) is amended—

(1) in the first sentence, by striking ", subject to the deductible and coinsurance provisions of this title,", and

(2) by adding at the end the following: "No item or service for which an individual is indemnified under this subsection shall be taken into account in applying any limitation on the amount of items and services for which payment may be made to or on behalf of the individual under this title.".

(c) PATIENT LIABILITY FOR HOSPITAL CHARGES DURING APPEAL OF DISCHARGE NOTICE.—

(1) Section 1154(e)(2) of such Act (42 U.S.C. 1320c-3(e)(2)) is amended by adding at the end thereof the following: "If the hospital requests such a review, it shall also notify the patient that the review has been requested.".

(2) Sections 1154(e)(3)(A)(i) (42 U.S.C. 1320c-3(e)(3)(A)(i)) and 1154(e)(3)(B) (42 U.S.C. 1320c-3(e)(3)(B)) of such Act are each amended by inserting "or (2)" after "paragraph (1)".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1988.

SEC. 4097. SEPARATE FUNDING LEVELS.

(a) AGGREGATE FUNDING.—Section 1866(a)(1)(F)(i)(III) of the Social Security Act (42 U.S.C. 1395cc(a)(1)(F)(i)(III)) is amended—

(1) by striking "1986" and inserting "1988"; and

(2) inserting "and for any direct or administrative costs incurred as a result of review functions added with respect to a subsequent fiscal year" after "inflation".

(b) PAYMENT.—Section 1866(a)(4)(C)(ii) of such Act (42 U.S.C. 1395cc(a)(4)(C)(ii)) is amended to read as follows:

"(ii) shall not be less in the aggregate for a fiscal year—

"(I) in the case of hospitals, than the amount specified in paragraph (1)(F)(i)(III), and

"(II) in the case of facilities and agencies, than the amounts the Secretary determines to be sufficient to cover the costs of such organizations' conducting the activities described in subparagraph (A) with respect to such facilities or agencies under part B of title XI.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to fiscal years beginning on or after October 1, 1988.

Subtitle B—Medicaid

PART 1—ELIGIBILITY AND BENEFITS

SEC. 4101. MEDICAID BENEFITS FOR POOR CHILDREN AND PREGNANT WOMEN.

(a) MEDICAID OPTIONAL COVERAGE FOR ADDITIONAL LOW-INCOME PREGNANT WOMEN AND CHILDREN.—

(1) Section 1902(l) of the Social Security Act (42 U.S.C. 1396a(l)) is amended—

(A) in paragraph (2)—

(i) by striking "(2) For purposes of paragraph (1)" and inserting "(2)(A) For purposes of paragraph (1) with respect to individuals described in subparagraph (A) or (B) of that paragraph",

(ii) by striking "100 percent" and inserting "185 percent", and

(iii) by adding at the end the following new subparagraph:

"(B) If a State elects, under subsection (a)(10)(A)(ii)(IX), to cover individuals not described in subparagraph (A) or (B) of paragraph (1), for purposes of that paragraph and with respect to individuals not described in such subparagraphs the State shall establish an income level which is a percentage (not more than 100 percent, or, if less, the percentage established under subparagraph (A)) of the income official poverty line described in subparagraph (A)."; and

(B) in paragraph (3)(D), by inserting "appropriate" after "applied is the".

(2) Section 1902(e)(4) of such Act (42 U.S.C. 1396a(e)(4)) is amended by adding at the end the following new sentence: "During the period in which a child is deemed under the preceding sentence to be eligible for medical assistance, the medical assistance eligibility identification number of the mother shall also serve as the identification number of the child, and all claims shall be submitted and paid under such number (unless the State issues a separate identification number for the child before such period expires).".

(3) The amendments made by this subsection shall apply to medical assistance furnished on or after July 1, 1988.

(b) ALLOWING ACCELERATED COVERAGE OF CHILDREN UP TO AGE 5.—

(1) Section 1902(l)(1) of such Act (42 U.S.C. 1396a(l)(1)) is amended—

(A) by inserting "and" at the end of subparagraph (B), and

(B) by striking subparagraphs (C) through (F) and inserting the following:

"(C) children born after September 30, 1983, and who have attained one year of age but have not attained 2, 3, 4, or 5 years of age (as selected by the State),".

(2)(A) Section 1902(l) of such Act is further amended—

(i) in paragraph (3)(C), by striking ", (C), (D), (E), or (F)" and inserting "or (C)", and

(ii) in paragraph (4)(B)(ii), by striking ", (D), (E), or (F)".

(B) Section 1902(e)(7) of such Act (42 U.S.C. 1396a(e)(7)) is amended by striking ", (C), (D), (E), or (F)" and inserting "or (C)".

(C) Section 9401(f)(2) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking "(A)" after "(2)" and by striking subparagraphs (B) through (D).

(3) The amendments made by this subsection shall apply with respect to medical assistance furnished on or after July 1, 1988.

(c) COVERAGE OF CHILDREN UP TO AGE 8.—

(1) Section 1905(n)(2) of such Act (42 U.S.C. 1396d(n)(2)) is amended by striking "is under 5 years of age" and inserting "has not attained the age of 7 (or any age designated by the State that exceeds 7 but does not exceed 8)".

(2) Section 1902(l)(1)(C) of such Act, as amended by subsection (b)(1)(B), is further amended by striking "or 5 years" and inserting "5, 6, 7, or 8 years".

(3)(A) The amendments made by this subsection shall apply to medical assistance furnished on or after October 1, 1988.

(B) For purposes of section 1905(n)(2) of the Social Security Act (as amended by subsection (a)) for medical assistance furnished during fiscal year 1989, any reference to "age of 7" is deemed to be a reference to "age of 6".

(d) PREMIUM.—

(1) Section 1916 of the Social Security Act (42 U.S.C. 1396o) is amended—

(A) in subsection (a)(1), by inserting "(except for a premium imposed under subsection (c))" before the semicolon;

(B) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(C) by inserting after subsection (b) the following new subsection:

"(c)(1) The State plan of a State may at the option of the State provide for imposing a monthly premium (in an amount that does not exceed the limit established under paragraph (2)) with respect to an individual described in subparagraph (A) or (B) of section 1902(l)(1) who is receiving medical assistance on the basis of section 1902(a)(10)(A)(ii)(IX) and whose family income (as determined in accordance with the methodology specified in section 1902(l)(3)) equals or exceeds 150 percent of the nonfarm income official poverty line

(as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(2) In no case may the amount of any premium imposed under paragraph (1) exceed 10 percent of the amount by which the family income (less expenses for the care of a dependent child) of an individual exceeds 150 percent of the line described in paragraph (1).

"(3) A State shall not require prepayment of a premium imposed pursuant to paragraph (1) and shall not terminate eligibility of an individual for medical assistance under this title on the basis of failure to pay any such premium until such failure continues for a period of not less than 60 days. The State may waive payment of any such premium in any case where the State determines that requiring such payment would create an undue hardship.

"(4) A State may permit State or local funds available under other programs to be used for payment of a premium imposed under paragraph (1). Payment of a premium with such funds shall not be counted as income to the individual with respect to whom such payment is made.".

(2) The amendments made by paragraph (1) shall become effective on July 1, 1988.

(e) MISCELLANEOUS PROVISIONS RELATING TO SERVICES FOR PREGNANT WOMEN AND CHILDREN.—

(1) Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)) is amended, in subdivision (VII) of the matter following subparagraph (E), by striking "and postpartum" and inserting "postpartum, and family planning".

(2) Section 1902(e)(5) of such Act (42 U.S.C. 1396a(e)(5)) is amended by striking "until the end of the 60-day period beginning on the last day of her pregnancy" and inserting "through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends".

(3) Section 1902(l)(3)(E) of such Act (42 U.S.C. 1396a(l)(3)(E)) is amended by inserting after "title IV" the following: "(except to the extent such methodology is inconsistent with clause (D) of subsection (a)(17))".

(4) Section 1902(l)(4)(A) of such Act (42 U.S.C. 1396a(l)(4)(A)) is amended by striking "April 17, 1986" and inserting "July 1, 1987".

(5) Section 1902(l)(4) of such Act (42 U.S.C. 1396a(l)(4)) is amended by adding at the end the following new subparagraph:

"(C) A State plan may not provide, in its election of the option of furnishing medical assistance to individuals described in paragraph (1), that such individuals must apply for benefits under part A of title IV as a condition of applying for, or receiving, medical assistance under this title.".

(6)(A) The amendment made by paragraphs (1) shall become effective on the date of enactment of this Act.

(B) The amendments made by paragraphs (2) and (3) shall be effective as if they had been included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985.

(C) The amendment made by paragraph (4) shall apply to elections made on or after the enactment of this Act.

(D) The amendment made by paragraph (5) shall apply as if included in the enactment of section 9401 of the Omnibus Budget Reconciliation Act of 1986.

SEC. 4102. HOME AND COMMUNITY-BASED SERVICES FOR THE ELDERLY.

(a) IN GENERAL.—

(1) Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended—

(A) by transferring subsection (d) to the end of such section and redesignating it as subsection (h), and

(B) by inserting after subsection (c) the following new subsection:

"(d)(1) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this title shall include as 'medical assistance' under such plan payment for part or all of the cost of home or community-based services (other than room and board) which are provided pursuant to a written plan of care to individuals 65 years of age or older with respect to whom there has been a determination that but for the provision of such services the individuals would be likely to require the level of care provided in a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan.

"(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

"(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

"(B) with respect to individuals 65 years of age or older who—

"(i) are entitled to medical assistance for skilled nursing or intermediate care facility services under the State plan,

"(ii) may require such services, and

"(iii) may be eligible for such home or community-based services under such waiver,

the State will provide for an evaluation of the need for such skilled nursing facility or intermediate care facility services; and

"(C) such individuals who are determined to be likely to require the level of care provided in a skilled nursing facility or intermediate care facility are informed of the feasible alternatives to the provision of skilled nursing facility or intermediate care facility services, which such individuals may choose if available under the waiver.

Each State with a waiver under this subsection shall provide to the Secretary annually, consistent with a reasonable data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

"(3) A waiver granted under this subsection may include a waiver of the requirements of section 1902(a)(1) (relating to statewideness), section 1902(a)(10)(B) (relating to comparability), and section

1902(a)(10)(C)(i)(III) (relating to income and resource rules applicable in the community). Subject to a termination by the State (with notice to the Secretary) at any time, a waiver under this subsection shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional 5-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under the waiver, that the maximum amount of the individual's income which may be disregarded for any month is equal to the amount that may be allowed for that purpose under a waiver under subsection (c).

"(4) A waiver under this subsection may, consistent with paragraph (2), provide medical assistance to individuals for case management services, homemaker/home health aide services and personal care services, adult day health services, respite care, and other medical and social services that can contribute to the health and well-being of individuals and their ability to reside in a community-based care setting.

"(5)(A) In the case of a State having a waiver approved under this subsection, notwithstanding any other provision of section 1903 to the contrary, the total amount expended by the State for medical assistance with respect to skilled nursing facility services, intermediate care facility services, and home and community-based services under the State plan for individuals 65 years of age or older during a waiver year under this subsection may not exceed the projected amount determined under subparagraph (B).

"(B) For purposes of subparagraph (A), the projected amount under this subparagraph is the sum of the following:

"(i) The aggregate amount of the State's medical assistance under this title for skilled nursing facility services and intermediate care facility services furnished to individuals who have attained the age of 65 for the base year increased by a percentage which is equal to the lesser of 7 percent times the number of years beginning after the base year and ending before the waiver year involved or the sum of—

"(I) the percentage increase (based on an appropriate market-basket index representing the costs of elements of such services) between the base year and the waiver year involved, plus

"(II) the percentage increase between the base year and the waiver year involved in the number of residents in the State who have attained the age of 65, plus

"(III) 2 percent for each year beginning after the base year and ending before the waiver year.

"(ii) The aggregate amount of the State's medical assistance under this title for home and community-based services for individuals who have attained the age of 65 for the base year increased by a percentage which is equal to the lesser of 7 percent times the number of years beginning after the base year and ending before the waiver year involved or the sum of—

"(I) the percentage increase (based on an appropriate market-basket index representing the costs of elements of

such services) between the base year and the waiver year involved, plus

"(II) the percentage increase between the base year and the waiver year involved in the number of residents in the State who have attained the age of 65, plus

"(III) 2 percent for each year beginning after the base year and ending before the waiver year.

"(iii) The Secretary shall develop and promulgate by regulation (by not later than October 1, 1989)—

"(I) a method, based on an index of appropriately weighted indicators of changes in the wages and prices of the mix of goods and services which comprise both skilled nursing facility services and intermediate care facility services (regardless of the source of payment for such services), for projecting the percentage increase for purposes of clause (i)(I);

"(II) a method, based on an index of appropriately weighted indicators of changes in the wages and prices of the mix of goods and services which comprise home- and community-based services (regardless of the source of payment for such services), for projecting the percentage increase for purposes of clause (ii)(I); and

"(III) a method for projecting, on a State specific basis, the percentage increase in the number of residents in each State who are over 75 years of age for any period.

Effective on and after the date the Secretary promulgates the regulation under clause (iii), any reference in this subparagraph to the 'lesser of 7 percent' shall be deemed to be a reference to the 'greater of 7 percent'.

"(C) In this paragraph:

"(i) The term 'home- and community-based services' includes services described in sections 1905(a)(7) and 1905(a)(8), services described in subsection (c)(4)(B), services described in paragraph (4)(B), personal care services, and services furnished pursuant to a waiver under subsection (c).

"(ii)(I) Subject to subclause (II), the term 'base year' means the most recent year (ending before the date of the enactment of this subsection) for which actual final expenditures under this title have been reported to, and accepted by, the Secretary.

"(II) For purposes of subparagraph (C), in the case of a State that does not report expenditures on the basis of the age categories described in such subparagraph for a year ending before the date of the enactment of this subsection, the term 'base year' means fiscal year 1989.

"(iii) The term 'intermediate care facility services' does not include services furnished in an institution certified in accordance with section 1905(d).

"(6)(A) A determination by the Secretary to deny a request for a waiver (or extension of waiver) under this subsection shall be subject to review to the extent provided under section 1116(b).

"(B) Notwithstanding any other provision of this Act, if the Secretary denies a request of the State for an extension of a waiver under this subsection, any waiver under this subsection in effect on the date such request is made shall remain in effect for a period of not less than 90 days after the date on which the Secretary denies such

request (or, if the State seeks review of such determination in accordance with subparagraph (A), the date on which a final determination is made with respect to such review).".

(2) The amendments made by paragraph (1) shall become effective on January 1, 1988.

(b) CONFORMING AMENDMENTS.—

(1) Section 1902(a)(10)(A)(ii)(VI) of such Act (42 U.S.C. 1396a(a)(10)(A)(ii)(VI)) is amended by striking "section 1915(c)" each place it appears and inserting "subsection (c) or (d) of section 1915".

(2) Section 1915(h) of such Act, as redesignated by subsection (a), is amended by striking "(c)" and inserting in lieu thereof "(c) or (d)".

(c) EXTENSION OF WAIVER.—In the case of a State which, as of December 1, 1987, has a waiver approved with respect to elderly individuals under section 1915(c) of the Social Security Act, which waiver is scheduled to expire before July 1, 1988, if the State notifies the Secretary of Health and Human Services of the State's intention to file an application for a waiver udner section 1915(d) of such Act (as amended by subsection (a) of this section), the Secretary shall extend approval of the State's waiver, under section 1915(c) of such Act, on the same terms and conditions through September 30, 1988.

SEC. 4103. PHYSICIANS' SERVICES FURNISHED BY DENTISTS.

(a) CLARIFYING COVERAGE.—Section 1905(a)(5) of the Social Security Act (42 U.S.C. 1396d(a)(5)) is amended by inserting "(A)" after "(5)" and by inserting before the semicolon at the end the following: ", and (B) medical and surgical services furnished by a dentist (described in section 1861(r)(2)) to the extent such services may be performed under State law either by a doctor of medicine or by a doctor of dental surgery or dental medicine and would be described in subparagraph (A) if furnished by a physician (as defined in section 1861(r)(1))".

(b) EFFECTIVE DATE.—

(1) The amendment made by subsection (a) applies (except as provided under paragraph (2)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after January 1, 1988, without regard to whether or not final regulations to carry out such amendment have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirement imposed by the amendment made by subsection (a), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet this additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act.

SEC. 4104. OPTIONAL MEDICAID COVERAGE OF INDIVIDUALS IN CERTAIN STATES RECEIVING ONLY OPTIONAL STATE SUPPLEMENTARY PAYMENTS.

Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(1) by striking "or" at the end of subclause (IX) and inserting "or" at the end of subclause (X); and

(2) by adding at the end the following new subclause:

> *"(XI) who receive only an optional State supplementary payment based on need and paid on a regular basis, equal to the difference between the individual's countable income and the income standard used to determine eligibility for such supplementary payment (with countable income being the income remaining after deductions as established by the State pursuant to standards that are more restrictive than the standards for supplementary security income benefits under title XVI), which are available to all individuals in the State (but which may be based on different income standards by political subdivision according to cost of living differences), and which are paid by a State that does not have an agreement with the Secretary under section 1616 or 1634.".*

SEC. 4105. CLARIFICATION OF COVERAGE OF CLINIC SERVICES FURNISHED TO HOMELESS OUTSIDE FACILITY.

(a) IN GENERAL.—Section 1905(a)(9) of the Social Security Act (42 U.S.C. 1396d(a)(9)) is amended by inserting before the semicolon at the end the following: ", including such services furnished outside the clinic by clinic personnel to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after January 1, 1988, without regard to whether regulations to implement such amendment are promulgated by such date.

SEC. 4106. MEDICALLY NEEDY INCOME LEVELS FOR CERTAIN 2-MEMBER COUPLES IN CALIFORNIA.

For purposes of section 1903(f)(1)(B) of the Social Security Act, for payments made to California on or after July 1, 1983, in the case of a family consisting only of two individuals both of whom are adults and at least one of whom is aged, blind, or disabled, the "highest amount which would ordinarily be paid to a family of the same size" under the State's plan approved under part A of title IV of such Act shall, at California's option, be the amount determined by the State agency to be the amount of the aid which would ordinarily be payable under such plan to a family which consists of one adult and two children and which is without any income or resources. Section 1902(a)(10)(C)(i)(III) of the Social Security Act shall not prevent California from establishing (under the previous sentence) an applicable income limitation for families described in that sentence which is greater than the income limitation applicable to other families, if California has an applicable income limitation under section 1903(f) of such Act which is equal to the maximum

applicable income limitation permitted consistent with paragraph (1)(B) of such section for families other than those described in the previous sentence.

PART 2—OTHER PROVISIONS

SEC. 4111. INCREASING THE MAXIMUM ANNUAL MEDICAID PAYMENTS THAT MAY BE MADE TO THE COMMONWEALTHS AND TERRITORIES.

(a) IN GENERAL.—Subsection (c) of section 1108 of the Social Security Act (42 U.S.C. 1308) is amended to read as follows:

"(c) The total amount certified by the Secretary under title XIX with respect to a fiscal year for payment to—

"(1) Puerto Rico shall not exceed (A) $73,400,000 for fiscal year 1988, (B) $76,200,000 for fiscal year 1989, and (C) $79,000,000 for fiscal year 1990 (and each succeeding fiscal year);

"(2) the Virgin Islands shall not exceed (A) $2,430,000 for fiscal year 1988, (B) $2,515,000 for fiscal year 1989, and (C) $2,600,000 for fiscal year 1990 (and each succeeding fiscal year);

"(3) Guam shall not exceed (A) $2,320,000 for fiscal year 1988, (B) $2,410,000 for fiscal year 1989, and (C) $2,500,000 for fiscal year 1990 (and each succeeding fiscal year);

"(4) the Northern Mariana Islands shall not exceed (A) $636,700 for fiscal year 1988, (B) $693,350 for fiscal year 1989, and (C) $750,000 for fiscal year 1990 (and each succeeding fiscal year); and

"(5) American Samoa shall not exceed (A) $1,330,000 for fiscal year 1988, (B) $1,390,000 for fiscal year 1989, and (C) $1,450,000 for fiscal year 1990 (and each succeeding fiscal year).".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to payments for fiscal years beginning with fiscal year 1988.

SEC. 4112. ADJUSTMENT IN MEDICAID PAYMENT FOR INPATIENT HOSPITAL SERVICES FURNISHED BY DISPROPORTIONATE SHARE HOSPITALS.

(a) IMPLEMENTATION OF REQUIREMENT.—

(1) A State's plan under title XIX of the Social Security Act shall not be considered to meet the requirement of section 1902(a)(13)(A) of such Act (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs), as of July 1, 1988, unless the State has submitted to the Secretary of Health and Human Services, by not later than such date, an amendment to such plan that—

(A) specifically defines the hospitals so described (and includes in such definition any disproportionate share hospital described in subsection (b)(1) which meets the requirement of subsection (d)), and

(B) provides, effective for inpatient hospital services provided not later than July 1, 1988, for an appropriate increase in the rate or amount of payment for such services provided by such hospitals, consistent with subsection (c).

(2)(A) In order to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1989, the State must submit to the Secretary of Health and Human Services by not later than such date, the State plan amendment described in paragraph (1), consistent with subsection (c).

(B) In order to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1990, the State must submit to the Secretary of Health and Human Services by not later than such date, the State plan amendment described in paragraph (1), consistent with subsection (c).

The Secretary shall, not later than June 30 of each year in which the State is required to submit an amendment under this subsection, review each such amendment for compliance with such requirement and by such date shall approve or disapprove each such amendment. If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment which meets such requirement. The requirement of this subsection may not be waived under section 1915(b)(4) of the Social Security Act.

(b) HOSPITALS DEEMED DISPROPORTIONATE SHARE.—

(1) For purposes of subsection (a)(1), a hospital which meets the requirement of subsection (d) is deemed to be a disproportionate share hospital if—

(A) the hospital's medicaid inpatient utilization rate (as defined in paragraph (2)) is at least one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State; or

(B) the hospital's low-income utilization rate (as defined in paragraph (3)) exceeds 25 percent.

(2) For purposes of paragraph (1)(A), the term "medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were eligible for medical assistance under the State plan approved under title XIX of the Social Security Act in a period, and the denominator of which is the total number of the hospital's inpatient days in that period.

(3) For purposes of paragraph (1)(B), the term "low-income utilization rate" means, for a hospital, the sum of—

(A) the fraction (expressed as a percentage)—

(i) the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for patient services under a State plan under title XIX of the Social Security Act and (II) the amount of the cash subsidies for patient services received directly from State and local governments, and

(ii) the denominator of which is the total amount of revenues of the hospital for patient services (including the amount of such cash subsidies) in the period; and

(B) a fraction (expressed as a percentage)—

(i) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, and

(ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under subparagraph (B)(i) shall not include contractual allowances and discounts (other than for indigent patients not eligible for medical assistance under a State plan approved under title XIX of the Social Security Act).

(c) PAYMENT ADJUSTMENT.—In order to be consistent with this subsection, a payment adjustment for a disproportionate share hospital must either—

(1) be in an amount equal to the product of (A) the amount paid under the State plan to the hospital for operating costs for inpatient hospital services (of the kind described in section 1886(a)(4)), and (B) the hospital's disproportionate share adjustment percentage (established under section 1886(d)(5)(F)(iv)); or

(2) provide for a minimum specified additional payment amount (or increased percentage payment) and for an increase in such a payment amount (or percentage payment) in proportion to the percentage by which the hospital's medicaid utilization rate (as defined in subsection (b)(2)) exceeds one standard deviation above the mean medicaid inpatient utilization rate for hospitals receiving medicaid payments in the State;

except that, for purposes of paragraphs (2)(A) and (2)(B), the payment adjustment for a disproportionate share hospital is consistent with this subsection if the appropriate increase in the rate or amount of payment is equal to one-third of the increase otherwise applicable under subsection (c) (in the case of paragraph (2)(A)) and two-thirds of such increase (in the case of paragraph (2)(B)).

(d) REQUIREMENT TO QUALIFY AS DISPROPORTIONATE SHARE HOSPITAL.—

(1) Except as provided in paragraph (2), no hospital may be defined or deemed as a disproportionate share hospital under a State plan under title XIX of the Social Security Act or under subsection (b) of this section unless the hospital has at least 2 obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to individuals who are entitled to medical assistance for such services under such State plan.

(2)(A) Paragraph (1) shall not apply to a hospital—

(i) the inpatients of which are predominantly individuals under 18 years of age; or

(ii) which does not offer nonemergency obstetric services to the general population as of the date of the enactment of this Act.

(B) In the case of a hospital located in a rural area (as defined for purposes of section 1886 of the Social Security Act), in paragraph (1) the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

(e) SPECIAL RULE.—A State plan shall be considered to meet the requirement of section 1902(a)(13)(A) (insofar as it requires payments to hospitals to take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs) without regard to the requirement of subsection (a) if the

plan provided for payment adjustments for disproportionate share hospitals as of January 1, 1984, and if the aggregate amount of the payment adjustments under the plan for such hospitals is not less than the aggregate amount of such adjustments otherwise required to be made under such subsection.

SEC. 4113. HMO-RELATED PROVISIONS.

(a) TREATMENT OF GARDEN STATE HEALTH PLAN.—

(1) Section 1903(m) of the Social Security Act (42 U.S.C. 1396(m)) is amended—

(A) by adding at the end the following new paragraph:

"(6)(A) For purposes of this subsection and section 1902(e)(2)(A), in the case of the State of New Jersey, the term 'contract' shall be deemed to include an undertaking by the State agency, in the State plan under this title, to operate a program meeting all requirements of this subsection.

"(B) The undertaking described in subparagraph (A) must provide—

"(i) for the establishment of a separate entity responsible for the operation of a program meeting the requirements of this subsection, which entity may be a subdivision of the State agency administering the State plan under this title;

"(ii) for separate accounting for the funds used to operate such program;

"(iii) for setting the capitation rates and any other payment rates for services provided in accordance with this subsection using a methodology satisfactory to the Secretary designed to ensure that total Federal matching payments under this title for such services will be lower than the matching payments that would be made for the same services, if provided under the State plan on a fee for service basis to an actuarially equivalent population; and

"(iv) that the State agency will contract, for purposes of meeting the requirement under section 1902(a)(30)(C), with an organization or entity that under section 1154 reviews services provided by an eligible organization pursuant to a contract under section 1876 for the purpose of determining whether the quality of services meets professionally recognized standards of health care.

"(C) The undertaking described in subparagraph (A) shall be subject to approval (and annual re-approval) by the Secretary in the same manner as a contract under this subsection.

"(D) The undertaking described in subparagraph (A) shall not be eligible for a waiver under section 1915(b).''; and

(B) in paragraph (2)(F), by striking all that precedes "a State plan may restrict" and inserting the following:

"(F) In the case of—

(i) a contract with an entity described in subparagraph (G) or with a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) which meets the requirement of subparagraph (A)(ii), or

"(ii) a program pursuant to an undertaking described in paragraph (6) in which at least 25 percent of the membership enrolled on a prepaid basis are individuals who (I) are not in-

sured for benefits under part B of title XVIII or eligible for benefits under this title, and (II) (in the case of such individuals whose prepayments are made in whole or in part by any government entity) had the opportunity at the time of enrollment in the program to elect other coverage of health care costs that would have been paid in whole or in part by any governmental entity,".

(2) Section 1902(e)(2)(A) of such Act (42 U.S.C. 1396a(e)(2)(A)) is amended by striking "section 1903(m)(2)(G)" and inserting "paragraph (2)(G) or (6) of section 1903(m)".

(b) MEDICAID MATCHING RATE FOR QUALITY REVIEW OF HMO SERVICES.—

(1) Section 1902(a)(30)(C) of such Act (42 U.S.C. 1396a(a)(30)(C)) is amended by inserting ", an entity which meets the requirements of section 1152, as determined by the Secretary," after "title XI)".

(2) Section 1902(d) of such Act (42 U.S.C. 1396a(d)) is amended—

(i) by inserting after "contracts with" the following: "an entity which meets the requirements of section 1152, as determined by the Secretary, for the performance of the quality review functions described in subsection (a)(30)(C), or", and

(ii) by striking "organization (or organizations)" each place it appears and inserting "such an entity or organization".

(3) Section 1903(a)(3)(C) of such Act (42 U.S.C. 1396b(a)(3)(C)) is amended by inserting "or by an entity which meets the requirements of section 1152, as determined by the Secretary," after "utilization and quality control peer review organization".

(c) FREEDOM OF CHOICE.—

(1) Section 1902(a)(23) of such Act (42 U.S.C. 1396a(a)(23)) is amended—

(A) by inserting "(A)" after "Guam, provide that", and

(B) by inserting before the semicolon at the end the following: ", and (B) an enrollment of an individual eligible for medical assistance in a primary care case-management system (described in section 1915(b)(1)), a health maintenance organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services under section 1905(a)(4)(C)".

(2) Section 1902(e)(2)(A) of such Act (42 U.S.C. 1396a(e)(2)(A)) is amended by striking "but only" and inserting "but, except for benefits furnished under section 1905(a)(4)(C), only".

(3) The amendments made by this subsection shall apply to services furnished on and after July 1, 1988.

(d) TECHNICAL AMENDMENTS.—

(1) Section 1903(m)(2)(F) of such Act (42 U.S.C. 1396b(m)(2)(F)) is amended by striking "subparagraph (G)" and inserting "subparagraphs (E) or (G)".

(2) Section 1902(e)(2)(A) of such Act (42 U.S.C. 1396a(e)(2)(A)) is amended by striking "section 1903(m)(2)(G)" and inserting "subparagraph (B)(iii), (E), or (G) of section 1903(m)(2)".

(e) CONTINUED ELIGIBILITY AND RESTRICTION ON DISENROLLMENT WITHOUT CAUSE FOR METROPOLITAN HEALTH PLAN HMO.—For purposes of sections 1902(e)(2)(A) and 1903(m)(2)(F) of the Social Security Act, the Metropolitan Health Plan HMO operated by the New York City public hospitals shall be treated in the same manner as a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act).

SEC. 4114. MEDICAID WAIVER FOR HOSPICE CARE FOR AIDS PATIENTS.

Section 1905(o)(1) of the Social Security Act (42 U.S.C. 1396d(o)(1)) is amended—

(1) by inserting "(A)" after "(1)";

(2) by striking "The" and inserting "Subject to subparagraph (B), the"; and

(3) by adding at the end the following new subparagraph:

"(B) For purposes of this title only, with respect to the definition of hospice program under section 1861(dd)(2), the Secretary may allow an agency or organization to make the assurance under subparagraph (A)(iii) of such section without taking into account any individual who is afflicted with acquired immunodeficiency syndrome.".

SEC. 4115. STATE DEMONSTRATION PROJECTS.

(a) EXTENSION OF ARIZONA HEALTH CARE DEMONSTRATION PROJECT.—

(1) Notwithstanding any limitations contained in section 1115 of the Social Security Act, but subject to paragraphs (2) and (3) of this subsection, the Secretary of Health and Human Services (in this subsection referred to as the "Secretary") upon application shall renew until September 30, 1989, approval of demonstration project number 11-P-98239/9-05 ("Arizona Health Care Cost Containment System—AHCCCS—A statewide approach to cost effective health care financing"), including all waivers granted by the Secretary under such section 1115 as of September 30, 1987.

(2) The Secretary's renewed approval of the project under paragraph (1) shall—

(A) subject to paragraph (3) be on the same terms and conditions that existed between the applicant and the Secretary as of September 30, 1987; and

(B) remain in effect through September 30, 1989, unless the Secretary finds that the applicant no longer complies with such terms and conditions.

(3) Nothing in this subsection shall be construed to prohibit or require the Secretary from granting additional waivers to the applicant—

(A) for coverage of additional optional groups, and

(B) for coverage of long-term care and other services which were not covered as of September 30, 1987.

(b) NEW YORK STATE PILOT PROGRAM FOR PRENATAL, MATERNITY, AND NEWBORN CARE.—

(1) Upon application by the State of New York and approval by the Secretary of Health and Human Services (in this subsection referred to as the "Secretary"), the State of New York (in this subsection referred to as the "State") may conduct a dem-

onstration project in accordance with this subsection for the purpose of testing its Prenatal/Maternity/Newborn Care Pilot Program (in this subsection referred to as the "Program"), as the Program is set forth in the Prenatal Care Act of 1987 (enacted by the State in February 1987), as an alternative to existing Federal programs.

(2) Under the demonstration project conducted under this subsection—

(A) any individual who receives benefits under the Program shall not receive any of such benefits under the plan of the State under title XIX of the Social Security Act; and

(B) the Secretary shall make payments to the State with respect to individuals receiving benefits under the Program in the same amounts as would be payable for such benefits under title XIX of the Social Security Act if such individuals were receiving such benefits under such title (as determined by the Secretary).

(3) The Secretary may (with respect to the demonstration project under this subsection) waive compliance with any requirement contained in section 1902(a)(1), 1902(a)(10)(B), 1902(a)(17)(D), 1902(a)(23), 1902(a)(30), or 1903(f) of the Social Security Act which (if applied) would prevent the State from carrying out the project, effectively achieving its purpose, or receiving payments in accordance with paragraph (2)(B).

(4) As a condition of approval of the demonstration project under this subsection, the State shall provide assurances satisfactory to the Secretary that—

(A) the State will continue to make benefits available under title XIX of the Social Security Act to all pregnant women entitled to receive benefits under such title to the extent such benefits are not provided under the Program; and

(B) the State has in effect a quality assurance mechanism to ensure the quality and accessability of the services furnished under the program.

(5)(A) The demonstration project under this subsection shall be conducted for a period not to exceed three years.

(B) The Secretary shall conduct an evaluation of the demonstration project under this subsection and shall report the results of such evaluation to the Congress not later than one year after completion of the project.

(c) WAIVERS FOR FAMILY INDEPENDENCE PROGRAM.—Upon approval of the demonstration project relating to the Family Independence Program in the State of Washington and with respect to such project, the Secretary of Health and Human Services shall waive compliance with any requirements of sections 1902(a)(1), 1916, and 1924 of the Social Security Act, but only to the extent necessary to enable the State to carry out the project as enacted by the State of Washington in May 1987.

SEC. 4116. WAIVER AUTHORITY UNDER THE MEDICAID PROGRAM FOR THE NORTHERN MARIANA ISLANDS.

Section 1902(j) of the Social Security Act (42 U.S.C. 1396a(j)) is amended—

(1) by inserting "and the Northern Mariana Islands" after "American Samoa" the first place it appears; and

(2) by inserting "or the Northern Mariana Islands" after "American Samoa" the second place it appears.

SEC. 4117. DELAY QUALITY CONTROL SANCTIONS FOR MEDICAID.

The Secretary of Health and Human Services shall not, prior to July 1, 1988, implement any reductions in payments to States pursuant to section 1903(u) of the Social Security Act (or any provision of law described in subsection (c) of section 133 of the Tax Equity and Fiscal Responsibility Act of 1982).

SEC. 4118. TECHNICAL AND MISCELLANEOUS AMENDMENTS.

(a) SECTION 2176 WAIVER TECHNICALS.—

(1) Section 1915(c)(3) of the Social Security Act (42 U.S.C. 1396n(c)(3)) is amended by striking "and section 1902(a)(10)(B) (relating to comparability)" and inserting ", section 1902(a)(10)(B) (relating to comparability), and section 1902(a)(10)(C)(i)(III) (relating to income and resource rules applicable in the community)".

(2) The amendment made by paragraph (1) shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986.

(b) INCREASE IN NUMBER OF INDIVIDUALS WHO MAY BE SERVED UNDER MODEL HOME AND COMMUNITY-BASED SERVICES WAIVERS.— Section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)) is amended by adding at the end the following new paragraph:

"(10) No waiver under this subsection shall limit by an amount less than 200 the number of individuals in the State who may receive home and community-based services under such waiver.".

(c) KATIE BECKETT TECHNICAL.—

(1) Section 1902(e)(3)(C) of such Act (42 U.S.C. 1396a(e)(3)(C)) is amended by striking "to have a supplemental security income (or State supplemental) payment made with respect to him under title XVI" and inserting "for medical assistance under the State plan under this title".

(2) The amendment made by paragraph (1) shall be effective as if it were included in section 134 of the Tax Equity and Fiscal Responsibility Act of 1982.

(d) ORGAN TRANSPLANT TECHNICAL.—

(1) Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)) is amended—

(A) in paragraph (1), by striking the period at the end and inserting "; or", and

(B) by adding at the end the following new sentence: "Nothing in paragraph (1) shall be construed as permitting a State to provide services under its plan under this title that are not reasonable in amount, duration, and scope to achieve their purpose.".

(2) The amendments made by paragraph (1) shall be effective as if included in the enactment of section 9507 of the Consolidated Omnibus Budget Reconciliation Act of 1985.

(e) CIVIL MONEY PENALTY AND EXCLUSION CLARIFICATIONS.—

(1) Section 1128A(a)(1) of the Social Security Act (42 U.S.C. 1320a-7(a)(1)), as amended by section 3(a)(1) of the Medicare and

Medicaid Patient and Program Protection Act of 1987 (Public Law 100-93), is amended by striking "or has reason to know" each place it appears and inserting "or should know".

(2) Section 1128(d)(3)(B) of the such Act (42 U.S.C. 1320a-6(d)(3)(B)), as amended by section 2 of the Medicare and Medicaid Patient and Program Protection Act of 1987 (Public Law 100-93), is amended—

(A) by inserting "(i)" after "(B)", and

(B) by adding at the end the following new clause:

"(ii) A State health care program may provide for a period of exclusion which is longer than the period of exclusion under a program under title XVIII.".

(3) The amendment made by paragraph (1) shall apply to activities occurring before, on, or after the date of the enactment of this Act.

(f) INCORPORATION OF CERTAIN PROVISIONS RELATING TO INDIAN HEALTH SERVICE FACILITIES.—

(1) Section 1911 of the Social Security Act (42 U.S.C. 1396j), as amended by section 4111(g)(8) of this title, is amended—

(A) by striking "or nursing facility" each place it appears and inserting ", nursing facility, or any other type of facility which provides services of a type otherwise covered under the State plan"; and

(B) by adding at the end the following new subsection:

"(c) The Secretary is authorized to enter into agreements with the State agency for the purpose of reimbursing such agency for health care and services provided in Indian Health Service facilities to Indians who are eligible for medical assistance under the State plan.".

(2) The amendments made by paragraph (1) shall apply to health care services performed on or after the date of the enactment of this Act.

(g) FRAIL ELDERLY DEMONSTRATION PROJECT WAIVERS.—

(1) Section 9412(b)(2) of the Omnibus Budget Reconciliation Act of 1986 is amended—

(A) in subparagraph (A), by inserting before the period at the end the following: ", including permitting the organization to assume progressively (over the initial 3-year period of the waiver) the full financial risk", and

(B) in subparagraph (B), by striking "be awarded a grant from the Robert Wood Johnson Foundation" and insert "participate in an organized initiative to replicate the findings of the On Lok long-term care demonstration project (described in section 603(c)(1) of the Social Security Amendments of 1983)".

(2) The amendments made by paragraph (1) shall take effect as though it were included in the Omnibus Budget Reconciliation Act of 1986.

(h) MEDICALLY NEEDY INCURRED EXPENSES.

(1) Section 1902(a)(17) of the Social Security Act (42 U.S.C. 1396a(a)(17)) is amended by striking "(whether in the form of insurance premiums or otherwise)" and inserting "(whether in the form of insurance premiums or otherwise and regardless of

whether such costs are reimbursed under another public program of the State or political subdivision thereof)".

(2) The amendment made by paragraph (1) shall apply to costs incurred after the date of the enactment of this Act.

(i) QUALIFICATIONS FOR CASE MANAGERS FOR INDIVIDUALS WITH DEVELOPMENT DISABILITIES AND CHRONIC MENTAL ILLNESS.—

(1) Section 1915(g)(1) of such Act (42 U.S.C. 1396n(g)(1)) is amended by adding at the end the following new sentence: "The State may limit the case managers available with respect to case management services for eligible individuals with developmental disabilities or with chronic mental illness in order to ensure that the case managers for such individuals are capable of ensuring that such individuals receive needed services.".

(2) The amendment made by paragraph (1) shall take effect as though it were included in the enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985.

(j) HABILITATION SERVICES EFFECTIVE DATE.—Effective as if included in the enactment of section 9502 of the Consolidated Omnibus Budget Reconciliation Act of 1985, subsection (j)(1) of such section is amended by inserting before the period at the end the following: "to individuals eligible for services under a waiver granted under section 1915(c) of the Social Security Act, without regard to whether such individuals were receiving institutional services before their participation in the waiver".

(k) SECTION 2176 WAIVER FOR INSTITUTIONALIZED DEVELOPMENTALLY DISABLED.—Section 1915(c)(7) of the Social Security Act (42 U.S.C. 1396n(c)(7)) is amended by inserting "(A)" after "(7)" and adding at the end the following new subparagraph:

"(B) In making estimates under paragraph (2)(D) in the case of a waiver that applies only to individuals with developmental disabilities who are inpatients in a skilled nursing facility or intermediate care facility and whom the State has determined, on the basis of an evaluation under paragraph (2)(B), to need the level of services provided by an intermediate care facility for the mentally retarded, the State may determine the average per capita expenditures that would have been made in a fiscal year for those individuals under the State plan on the basis of the average per capita expenditures under the State plan for services to individuals who are inpatients in an intermediate care facility for the mentally retarded.".

(l) RENEWAL OF FREEDOM-OF-CHOICE WAIVERS.—

(1) Section 1915(h) of such Act (42 U.S.C. 1396n(h)) is amended by striking "denies such request in writing within 90 days after the date of its submission to the Secretary." and inserting ", within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 day of such date, denies such request.".

(2) The amendment made by paragraph (1) shall apply to requests for continuation of waivers received after the date of the enactment of this Act.

(m) REPEAL OF COORDINATED AUDIT REQUIREMENT.—

(1)(A) Section 1129 of such Act (42 U.S.C. 1320a–8) is repealed.

(B) Section 1902(a)(42) of such Act (42 U.S.C. 1396a(a)(42)) is amended—

(i) by striking "(A)", and

(ii) by striking ", (B)" and all that follows up to the semicolon at the end.

(2) The amendments made by paragraph (1) shall apply to audits conducted after the date of the enactment of this Act.

(n) TEMPORARY TECHNICAL ERROR DEFINITION.—For purposes of section 1903(u)(1)(E)(ii) of the Social Security Act, effective for the period beginning on the date of enactment of this Act and ending December 31, 1988, a "technical error" is an error in eligibility condition (such as assignment of social security numbers and assignment of rights to third-party benefits as a condition of eligibility) that, if corrected, would not result in a difference in the amount of medical assistance paid.

(o) TECHNICAL AMENDMENTS RELATING TO NEW JERSEY RESPITE CARE PILOT PROJECT.—

(1) Section 9414(b) of the Omnibus Budget Reconciliation Act of 1986 is amended—

(A) by redesignating paragraphs (2), (3), and (4), as paragraphs (3), (4), and (5), respectively,

(B) by inserting after paragraph (1) the following new paragraph:

"(2) provide that the State may submit a detailed proposal describing the project (in lieu of a formal request for the waiver of applicable provisions of title XIX of the Social Security Act) and that submission of such a description by the State will be treated as such a request for purposes of subsection (g),", and

(C) in paragraph (3), as redesignated by paragraph (1) of this subsection, by striking "if the project" and all that follows through "Act" the second place it appears and inserting "the State shall utilize a post-eligibility cost-sharing formula based on the available income of participants with income in excess of the nonfarm income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981)".

(2)(A) Section 9414(a) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking "elderly and disabled individuals" and inserting "eligible individuals".

(B) Section 9414(c) of the Omnibus Budget Reconciliation Act of 1986 is amended to read as follows:

"(c) Definitions.—For purposes of this section—

"(1) the term 'eligible individual' means an individual—

"(A) who is elderly or disabled,

"(B)(i) whose income (not including the income of the spouse or family of the individual) does not exceed 300 percent of the amount in effect under section 1611(a)(1)(A) of the Social Security Act (as increased pursuant to section 1617 of such Act), or

"(ii) in the case of an individual and spouse who are both dependent on a caregiver, whose combined incomes do not exceed such amount,

"(C) whose liquid resources (as declared by the individual) do not exceed $40,000,

"(D) who is at risk of institutionalization unless the individual's caregiver is provided with respite care, and

"(E) who has been determined to meet the requirements of subparagraphs (A) through (D) in accordance with an application process designed by the State; and

"(2) the term 'respite care services' shall include—

"(A) short-term and intermittent—

"(i) companion or sitter services (paid as well as volunteer),

"(ii) homemaker and personal care services,

"(iii) adult day care, and

"(iv) inpatient care in a hospital, a skilled nursing facility, or an intermediate care facility (not to exceed a total of 14 days for any individual), and

"(B) peer support and training for family caregivers (using informal support groups and organized counseling).".

(3) Section 9414(g) of the Omnibus Budget Reconciliation Act of 1986 is amended by inserting "section 1902(a)(10)(C)(i)(III)," after "section 1902(a)(10)(B),".

(4) The amendments made by this subsection shall be effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986.

(p) MISCELLANEOUS TECHNICAL CORRECTIONS.—

(1) Subclause (IX) of section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended by moving it 4 ems to the right so as to align its left margin with that of subclause (VIII) of that section.

(2) Subclause (X) of section 1902(a)(10)(A)(ii) of such Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended by moving it 2 ems to the right so as to align its left margin with that of subclause (VIII) of that section.

(3) Section 1902(a)(17) of such Act (42 U.S.C. 1396a(a)(17)) is amended by striking "subsection (l)(3)" and inserting "subsections (l)(3), (m)(4), and (m)(5)".

(4) Section 1902(a)(30)(C) of such Act (42 U.S.C. 1396(a)(30)(C)) is amended by striking "provide" and inserting "use".

(5) Section 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amended by inserting ", 1902(a)(10)(A)(ii)(X), or 1905(p)(1)" after "1902(a)(10)(A)(ii)(IX)".

(6) Paragraph (9) of section 1902(e) of such Act (42 U.S.C. 1396a(e)) is amended by moving the paragraph 2 ems to the left so as to align the left margin of subparagraph (A) (before clause (i)) and subparagraphs (B) and (C) with the left margin of paragraph (8).

(7) Section 1902(l)(1) of such Act (42 U.S.C. 1396a(l)(1)) is amended—

(A) by striking "(1)(l) Individuals" and inserting "(l)(1) Individuals",

(B) by moving the matter before subparagraph (A) 2 ems to the left so it is indented only once, and

(C) by striking ", whose" and inserting "and whose".

(8) Sections 1902(l)(2), 1902(m)(2)(A), 1905(p)(2)(A), and 501(b)(2) of such Act (42 U.S.C. 1396a(l)(2), 1396a(m)(2)(A), 1396d(p)(2)(A), 701(b)(2)) are each amended by striking "non-farm".

(9) Paragraphs (1) and (2) of section 1925(a), as redesignated by section [4111(a)] of this title, are amended to read as follows:

"(1) AFDC.—(A) Section 402(a)(32) of this Act (relating to individuals who are deemed recipients of aid but for whom a payment is not made).

"(B) Section 402(a)(37) of this Act (relating to individuals who lose AFDC eligibility due to increased earnings).

"(C) Section 406(h) of this Act (relating to individuals who lose AFDC eligibility due to increased collection of child or spousal support).

"(D) Section 414(g) of this Act (relating to certain individuals participating in work supplementation programs).

"(2) SSI.—(A) Section 1611(e) of this Act (relating to treatment of couples sharing an accommodation in a facility).

"(B) Section 1619 of this Act (relating to benefits for individuals who perform substantial gainful activity despite severe medical impairment).

"(C) Section 1634(b) of this Act (relating to preservation of benefit status for disabled widows and widowers who lost SSI benefits because of 1983 changes in actuarial reduction formula).

"(D) Section 1634(c) of this Act (relating to individuals who lose eligibility for SSI benefits due to entitlement to child's insurance benefits under section 202(d) of this Act).".

(10) Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986, section 9411(a)(2)(B) of such Act is amended by inserting "such" after "need for".

Subtitle C—Nursing Home Reform

PART 1—MEDICARE PROGRAM

SEC. 4201. REQUIREMENTS FOR SKILLED NURSING FACILITIES.

(a) SPECIFICATION OF FACILITY REQUIREMENTS.—Title XVIII of the Social Security Act is amended—

(1) by amending subsection (j) of section 1861 (42 U.S.C. 1395x) to read as follows:

"Skilled Nursing Facility

"(j) The term 'skilled nursing facility' has the meaning given such term in section 1819(a).";

(2) by adding at the end of section 1864 (42 U.S.C. 1395aa) the following new subsection:

"(d) The Secretary may not enter an agreement under this section with a State with respect to determining whether an institution

therein is a skilled nursing facility unless the State meets the requirements specified in section 1819(e).''; and

(3) by adding at the end of part A the following new section:

''REQUIREMENTS FOR, AND ASSURING QUALITY OF CARE IN, SKILLED NURSING FACILITIES

''SEC. 1819. (a) SKILLED NURSING FACILITY DEFINED.—In this title, the term 'skilled nursing facility' means an institution (or a distinct part of an institution) which—

''(1) is primarily engaged in providing to residents—

''(A) skilled nursing care and related services for residents who require medical or nursing care, or

''(B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons,

and is not primarily for the care and treatment of mental diseases;

''(2) has in effect a transfer agreement (meeting the requirements of section 1861(l)) with one or more hospitals having agreements in effect under section 1866; and

''(3) meets the requirements for a skilled nursing facility described in subsections (b), (c), and (d) of this section.

''(b) REQUIREMENTS RELATING TO PROVISION OF SERVICES.—

''(1) QUALITY OF LIFE.—

''(A) IN GENERAL.—A skilled nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

''(B) QUALITY ASSESSMENT AND ASSURANCE.—A skilled nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies.

''(2) SCOPE OF SERVICES AND ACTIVITIES UNDER PLAN OF CARE.—A skilled nursing facility must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care which—

''(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

''(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

''(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

''(3) RESIDENTS' ASSESSMENT.—

''(A) REQUIREMENT.—A skilled nursing facility must conduct a comprehensive, accurate, standardized, reproducible

assessment of each resident's functional capacity, which assessment—

"(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;

"(ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A);

"(iii) in the case of a resident eligible for benefits under title XIX, uses an instrument which is specified by the State under subsection (e)(5); and

"(iv) in the case of a resident eligible for benefits under part A of this title, includes the identification of medical problems.

"(B) CERTIFICATION.—

"(i) IN GENERAL.—Each such assessment must be conducted or coordinated (with the appropriate participation of health professionals) by a registered professional nurse who signs and certifies the completion of the assessment. Each individual who completes a portion of such an assessment shall sign and certify as to the accuracy of that portion of the assessment.

"(ii) PENALTY FOR FALSIFICATION.—

"(I) An individual who willfully and knowingly certifies under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 with respect to each assessment.

"(II) An individual who willfully and knowingly causes another individual to certify under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 with respect to each assessment.

"(III) The Secretary shall provide for imposition of civil money penalties under this clause in a manner similar to that for the imposition of civil money penalties under section 1128A.

"(iii) USE OF INDEPENDENT ASSESSORS.—If a State determines, under a survey under subsection (g) or otherwise, that there has been a knowing and willful certification of false assessments under this paragraph, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the State.

"(C) FREQUENCY.—

"(i) IN GENERAL.—Such an assessment must be conducted—

"(I) promptly upon (but no later than 4 days after the date of) admission for each individual admitted on or after October 1, 1990, and by not later than October 1, 1990, for each resident of the facility on that date;

"(II) promptly after a significant change in the resident's physical or mental condition; and

"(III) in no case less often than once every 12 months.

"(ii) RESIDENT REVIEW.—The skilled nursing facility must examine each resident no less frequently than once every 3 months and, as appropriate, revise the resident's assessment to assure the continuing accuracy of the assessment.

"(D) USE.—The results of such an assessment shall be used in developing, reviewing, and revising the resident's plan of care under paragraph (2).

"(E) COORDINATION.—Such assessments shall be coordinated with any State-required preadmission screening program to the maximum extent practicable in order to avoid duplicative testing and effort.

"(4) PROVISION OF SERVICES AND ACTIVITIES.—

"(A) IN GENERAL.—To the extent needed to fulfill all plans of care described in paragraph (2), a skilled nursing facility must provide, directly or under arrangements (or, with respect to dental services, under agreements) with others for the provision of—

"(i) nursing services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

"(ii) medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

"(iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident;

"(iv) dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident;

"(v) an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident; and

"(vi) routine and emergency dental services to meet the needs of each resident.

The services provided or arranged by the facility must meet professional standards of quality. Nothing in clause (vi) shall be construed as requiring a facility to provide or arrange for dental services described in that clause without additional charge.

"(B) QUALIFIED PERSONS PROVIDING SERVICES.—Services described in clauses (i), (ii), (iii), (iv), and (vi) of subparagraph (A) must be provided by qualified persons in accordance with each resident's written plan of care.

"(C) REQUIRED NURSING CARE.—

"(i) IN GENERAL.—Except as provided in clause (ii), a skilled nursing facility must provide 24-hour nursing service which is sufficient to meet nursing needs of its residents and must employ the services of a registered

professional nurse at least during the day tour of duty (of at least 8 hours a day) 7 days a week.

"(ii) EXCEPTION.—To the extent that clause (i) may be deemed to require that a skilled nursing facility engage the services of a registered professional nurse for more than 40 hours a week, the Secretary is authorized to waive such requirement if the Secretary finds that—

"(I) the facility is located in a rural area and the supply of skilled nursing facility services in such area is not sufficient to meet the needs of individuals residing therein,

"(II) the facility has one full-time registered professional nurse who is regularly on duty at such facility 40 hours a week, and

"(III) the facility either has only patients whose physicians have indicated (through physicians' orders or admission notes) that each such patient does not require the services of a registered nurse or a physician for a 48-hour period, or has made arrangements for a registered professional nurse or a physician to spend such time at such facility as may be indicated as necessary by the physician to provide necessary skilled nursing services on days when the regular full-time registered professional nurse is not on duty.

A waiver under this subparagraph shall be subject to annual renewal.

"(5) REQUIRED TRAINING OF NURSE AIDES.—

"(A) IN GENERAL.—A skilled nursing facility must not use (on a full-time, temporary, per diem, or other basis) any individual, who is not a licensed health professional (as defined in subparagraph (E)), as a nurse aide in the facility on or after October 1, 1989, (or January 1, 1990, in the case of an individual used by the facility as a nurse aide before July 1, 1989) for more than 4 months unless the individual—

"(i) has completed a training and competency evaluation program, or a competency evaluation program, approved by the State under subsection (e)(1)(A), and

"(ii) is competent to provide such services.

"(B) OFFERING COMPETENCY EVALUATION PROGRAMS FOR CURRENT EMPLOYEES.—A skilled nursing facility must provide, for individuals used as a nurse aide by the facility as of July 1, 1989, for a competency evaluation program approved by the State under subsection (e)(1) and such preparation as may be necessary for the individual to complete such a program by January 1, 1990.

"(C) COMPETENCY.—The skilled nursing facility must not permit an individual, other than in a training and competency evaluation program or a competency evaluation program approved by the State, to serve as a nurse aide or provide services of a type for which the individual has not demonstrated competency and must not use such an indi-

vidual as a nurse aide unless the facility has inquired of the State registry established under subsection (e)(2)(A) as to information in the registry concerning the individual.

"(D) RE-TRAINING REQUIRED.—For purposes of subparagraph (A), if, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual performed nursing or nursing-related services for monetary compensation, such individual shall complete a new training and competency evaluation program.

"(E) REGULAR IN-SERVICE EDUCATION.—The skilled nursing facility must provide such regular performance review and regular in-service education as assures that individuals used as nurse aides are competent to perform services as nurse aides, including training for individuals providing nursing and nursing-related services to residents with cognitive impairments.

"(F) NURSE AIDE DEFINED.—In this paragraph, the term 'nurse aide' means any individual providing nursing or nursing-related services to residents in a skilled nursing facility, but does not include an individual—

"(i) who is a licensed health professional (as defined in subparagraph (G)), or

"(ii) who volunteers to provide such services without monetary compensation.

"(G) LICENSED HEALTH PROFESSIONAL DEFINED.—In this paragraph, the term 'licensed health professional' means a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapist, registered professional nurse, licensed practical nurse, or licensed or certified social worker.

"(6) PHYSICIAN SUPERVISION AND CLINICAL RECORDS.—A skilled nursing facility must—

"(A) require that the medical care of every resident be provided under the supervision of a physician;

"(B) provide for having a physician available to furnish necessary medical care in case of emergency; and

"(C) maintain clinical records on all residents, which records include the plans of care (described in paragraph (2)) and the residents' assessments (described in paragraph (3)).

"(7) REQUIRED SOCIAL SERVICES.—In the case of a skilled nursing facility with more than 120 beds, the facility must have at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications) employed full-time to provide or assure the provision of social services.

"(c) REQUIREMENTS RELATING TO RESIDENTS' RIGHTS.—

"(1) GENERAL RIGHTS.—

"(A) SPECIFIED RIGHTS.—A skilled nursing facility must protect and promote the rights of each resident, including each of the following rights:

"(i) FREE CHOICE.—The right to choose a personal attending physician, to be fully informed in advance

about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

"(ii) FREE FROM RESTRAINTS.—The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed—

"(I) to ensure the physical safety of the resident or other residents, and

"(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary) until such an order could reasonably be obtained.

"(iii) PRIVACY.—The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups.

"(iv) CONFIDENTIALITY.—The right to confidentiality of personal and clinical records.

"(v) ACCOMMODATION OF NEEDS.—The right—

"(I) to reside and receive services with reasonable accommodations of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered, and

"(II) to receive notice before the room or roommate of the resident in the facility is changed.

"(vi) GRIEVANCES.—The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

"(vii) PARTICIPATION IN RESIDENT AND FAMILY GROUPS.—The right of the resident to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.

"(ix) PARTICIPATION IN OTHER ACTIVITIES.—The right of the resident to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

"(x) EXAMINATION OF SURVEY RESULTS.—The right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Secretary or a State with respect to the facility and any plan of correction in effect with respect to the facility.

"(xi) OTHER RIGHTS.—Any other right established by the Secretary.

Clause (iii) shall not be construed as requiring the provision of a private room.

"(B) NOTICE OF RIGHTS AND SERVICES.—A skilled nursing facility must—

"(i) inform each resident, orally and in writing at the time of admission to the facility, of the resident's legal rights during the stay at the facility;

"(ii) make available to each resident, upon reasonable request, a written statement of such rights (which statement is updated upon changes in such rights); and

"(iii) inform each other resident, in writing before or at the time of admission and periodically during the resident's stay, of services available in the facility and of related charges for such services, including any charges for services not covered under this title or by the facility's basic per diem charge.

The written description of legal rights under this subparagraph shall include a description of the protection of personal funds under paragraph (6) and a statement that a resident may file a complaint with a State survey and certification agency respecting resident abuse and neglect and misappropriation of resident property in the facility.

"(C) RIGHTS OF INCOMPETENT RESIDENTS.—In the case of a resident adjudged incompetent under the laws of a State, the rights of the resident under this title shall devolve upon, and, to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the resident's behalf.

"(2) TRANSFER AND DISCHARGE RIGHTS.—

"(A) IN GENERAL.—A skilled nursing facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless—

"(i) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;

"(ii) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

"(iii) the safety of individuals in the facility is endangered;

"(iv) the health of individuals in the facility would otherwise be endangered;

"(v) the resident has failed, after reasonable and appropriate notice, to pay (or to have paid under this title or title XIX on the resident's behalf) an allowable charge imposed by the facility for an item or service requested by the resident and for which a charge may be imposed consistent with this title and title XIX; or

"(vi) the facility ceases to operate.

In each of the cases described in clauses (i) through (v), the basis for the transfer or discharge must be documented in

the resident's clinical record. In the cases described in clauses (i) and (ii), the documentation must be made by the resident's physician, and in the cases described in clauses (iii) and (iv) the documentation must be made by a physician.

"(B) PRE-TRANSFER AND PRE-DISCHARGE NOTICE.—

"(i) IN GENERAL.—Before effecting a transfer or discharge of a resident, a skilled nursing facility must—

"(I) notify the resident (and, if known, a family member of the resident or legal representative) of the transfer or discharge and the reasons therefor,

"(II) record the reasons in the resident's clinical record (including any documentation required under subparagraph (A)), and

"(III) include in the notice the items described in clause (iii).

"(ii) TIMING OF NOTICE.—The notice under clause (i)(I) must be made at least 30 days in advance of the resident's transfer or discharge except—

"(I) in a case described in clause (iii) or (iv) of subparagraph (A);

"(II) in a case described in clause (ii) of subparagraph (A), where the resident's health improves sufficiently to allow a more immediate transfer or discharge;

"(III) in a case described in clause (i) of subparagraph (A), where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs; or

"(IV) in a case where a resident has not resided in the facility for 30 days.

In the case of such exceptions, notice must be given as many days before the date of the transfer or discharge as is practicable.

"(iii) ITEMS INCLUDED IN NOTICE.—Each notice under clause (i) must include—

"(I) for transfers or discharges effected on or after October 1, 1990, notice of the resident's right to appeal the transfer or discharge under the State process established under subsection (e)(3); and

"(II) the name, mailing address, and telephone number of the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965).

"(C) ORIENTATION.—A skilled nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

"(3) ACCESS AND VISITATION RIGHTS.—A skilled nursing facility must—

"(A) permit immediate access to any resident by any representative of the Secretary, by any representative of the State, by an ombudsman described in paragraph (2)(B)(iii)(II), or by the resident's individual physician;

"(B) permit immediate access to a resident, subject to the resident's right to deny or withdraw consent at any time, by immediate family or other relatives of the resident;

"(C) permit immediate access to a resident, subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, by others who are visiting with the consent of the resident;

"(D) permit reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and

"(E) permit representatives of the State ombudsman (described in paragraph (2)(B)(iii)(II)), with the permission of the resident (or the resident's legal representative) and consistent with State law, to examine a resident's clinical records.

"(4) EQUAL ACCESS TO QUALITY CARE.—A skilled nursing facility must establish and maintain identical policies and practices regarding transfer, discharge, and covered services under this title for all individuals regardless of source of payment.

"(5) ADMISSIONS POLICY.—

"(A) ADMISSIONS.—With respect to admissions practices, a skilled nursing facility must—

"(i)(I) not require individuals applying to reside or residing in the facility to waive their rights to benefits under this title or under a State plan under title XIX, (II) not require oral or written assurance that such individuals are not eligible for, or will not apply for, benefits under this title or such a State plan, and (III) prominently display in the facility and provide to such individuals written information about how to apply for and use such benefits and how to receive refunds for previous payments covered by such benefits; and

"(ii) not require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility.

"(B) CONSTRUCTION.—

"(i) NO PREEMPTION OF STRICTER STANDARDS.—Subparagraph (A) shall not be construed as preventing States or political subdivisions therein from prohibiting, under State or local law, the discrimination against individuals who are entitled to medical assistance under this title with respect to admissions practices of skilled nursing facilities.

"(ii) CONTRACTS WITH LEGAL REPRESENTATIVES.—Subparagraph (A)(ii) shall not be construed as preventing a facility from requiring an individual, who has legal access to a resident's income or resources available to pay for care in the facility, to sign a contract (without incurring personal financial liability) to provide payment from the resident's income or resources for such care.

"(6) PROTECTION OF RESIDENT FUNDS.—

"(A) IN GENERAL.—The skilled nursing facility—

"(i) may not require residents to deposit their personal funds with the facility, and

"(ii) once the facility accepts the written authorization of the resident, must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this paragraph.

"(B) MANAGEMENT OF PERSONAL FUNDS.—Upon a facility's acceptance of written authorization of a resident under subparagraph (A)(ii), the facility must manage and account for the personal funds of the resident deposited with the facility as follows:

"(i) DEPOSIT.—The facility must deposit any amount of personal funds in excess of $50 with respect to a resident in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the facility must maintain such funds in a non-interest bearing account or petty cash fund.

"(ii) ACCOUNTING AND RECORDS.—The facility must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a resident deposited with the facility, and afford the resident (or a legal representative of the resident) reasonable access to such record.

"(iii) CONVEYANCE UPON DEATH.—Upon the death of a resident with such an account, the facility must convey promptly the resident's personal funds (and a final accounting of such funds) to the individual administering the resident's estate.

"(C) ASSURANCE OF FINANCIAL SECURITY.—The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

"(D) LIMITATION ON CHARGES TO PERSONAL FUNDS.—The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under this title or title XIX.

"(d) REQUIREMENTS RELATING TO ADMINISTRATION AND OTHER MATTERS.—

"(1) ADMINISTRATION.—

"(A) IN GENERAL.—A skilled nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident (consistent with requirements established under subsection (f)(5)).

"(B) REQUIRED NOTICES.—If a change occurs in—

"(i) the persons with an ownership or control interest (as defined in section 1124(a)(3)) in the facility,

"(ii) the persons who are officers, directors, agents, or managing employees (as defined in section 1126(b)) of the facility,

"(iii) the corporation, association, or other company responsible for the management of the facility, or

"(iv) the individual who is the administrator or director of nursing of the facility,

the skilled nursing facility must provide notice to the State agency responsible for the licensing of the facility, at the time of the change, of the change and of the identity of each new person, company, or individual described in the respective clause.

"(C) SKILLED NURSING FACILITY ADMINISTRATOR.—The administrator of a skilled nursing facility must meet standards established by the Secretary under subsection (f)(4).

"(2) LICENSING AND LIFE SAFETY CODE.—

"(A) LICENSING.—A skilled nursing facility must be licensed under applicable State and local law.

"(B) LIFE SAFETY CODE.—A skilled nursing facility must meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes; except that—

"(i) the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a facility, but only if such waiver would not adversely affect the health and safety of residents or personnel, and

"(ii) the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects residents of and personnel in skilled nursing facilities.

"(3) SANITARY AND INFECTION CONTROL AND PHYSICAL ENVIRONMENT.—A skilled nursing facility must—

"(A) establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection, and

"(B) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents, personnel, and the general public.

"(4) MISCELLANEOUS.—

"(A) COMPLIANCE WITH FEDERAL, STATE, AND LOCAL LAWS AND PROFESSIONAL STANDARDS.—A skilled nursing facility must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations (including the requirements of section 1124) and with accepted professional standards and principles which apply to professionals providing services in such a facility.

"(B) OTHER.—A skilled nursing facility must meet such other requirements relating to the health, safety, and well-

being of residents or relating to the physical facilities thereof as the Secretary may find necessary.

"(e) STATE REQUIREMENTS RELATING TO SKILLED NURSING FACILITY REQUIREMENTS.—The requirements, referred to in section 1864(d), with respect to a State are as follows:

"(1) SPECIFICATION AND REVIEW OF NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS AND OF NURSE AIDE COMPETENCY EVALUATION PROGRAMS.—The State must—

"(A) by not later than March 1, 1989, specify those training and competency evaluation programs, and those competency evaluation programs, that the State approves for purposes of subsection (b)(5) and that meet the requirements established under clause (i) or (ii) of subsection (f)(2)(A), and

"(B) by not later than March 1, 1990, provide for the review and reapproval of such programs, at a frequency and using a methodology consistent with the requirements established under subsection (f)(2)(A)(iii).

The failure of the Secretary to establish requirements under subsection (f)(2) shall not relieve any State of its responsibility under this paragraph.

"(2) NURSE AIDE REGISTRY.—

"(A) IN GENERAL.—By not later than March 1, 1989, the State shall establish and maintain a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program, or a nurse aide competency evaluation program, approved under paragraph (1) in the State.

"(B) INFORMATION IN REGISTRY.—The registry under subparagraph (A) shall provide (in accordance with regulations of the Secretary) for the inclusion of specific documented findings by a State under subsection (g)(1)(C) of resident neglect or abuse or misappropriation of resident property involving an individual listed in the registry, as well as any brief statement of the individual disputing the findings. In the case of inquiries to the registry concerning an individual listed in the registry, any information disclosed concerning such a finding shall also include disclosure of any such statement in the registry relating to the finding or a clear and accurate summary of such a statement.

"(3) STATE APPEALS PROCESS FOR TRANSFERS.—The State, for transfers from skilled nursing facilities effected on or after October 1, 1990, must provide for a fair mechanism for hearing appeals on transfers of residents of such facilities. Such mechanism must meet the guidelines established by the Secretary under subsection (f)(3); but the failure of the Secretary to establish such guidelines shall not relieve any State of its responsibility to provide for such a fair mechanism.

"(4) SKILLED NURSING FACILITY ADMINISTRATOR STANDARDS.—By not later than January 1, 1990, the State must have implemented and enforced the skilled nursing facility administrator standards developed under subsection (f)(4) respecting the qualification of administrators of skilled nursing facilities.

"(5) SPECIFICATION OF RESIDENT ASSESSMENT INSTRUMENT.—Effective July 1, 1989, the State shall specify the instrument to

be used by nursing facilities in the State in complying with the requirement of subsection (b)(3)(A)(iii). Such instrument shall be—

"(A) one of the instruments designated under subsection (f)(6)(B), or

"(B) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary under subsection (f)(6)(A).

"(f) RESPONSIBILITIES OF SECRETARY RELATING TO SKILLED NURSING FACILITY REQUIREMENTS.—

"(1) GENERAL RESPONSIBILITY.—It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in skilled nursing facilities under this title, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.

"(2) REQUIREMENTS FOR NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS AND FOR NURSE AIDE COMPETENCY EVALUATION PROGRAMS.—

"(A) IN GENERAL.—For purposes of subsections (b)(5) and (e)(1)(A), the Secretary shall establish, by not later than September 1, 1988—

"(i) requirements for the approval of nurse aide training and competency evaluation programs, including requirements relating to (I) the areas to be covered in such a program (including at least basic nursing skills, personal care skills, cognitive, behavioral and social care, basic restorative services, and residents' rights), content of the curriculum, (II) minimum hours of initial and ongoing training and retraining (including not less than 75 hours in the case of initial training), (III) qualifications of instructors, and (IV) procedures for determination of competency;

"(ii) requirements for the approval of nurse aide competency evaluation programs, including requirement relating to the areas to be covered in such a program, including at least basic nursing skills, personal care skills, cognitive, behavioral and social care, basic restorative services, residents' rights, and procedures for determination of competency; and

"(iii) requirements respecting the minimum frequency and methodology to be used by a State in reviewing such programs' compliance with the requirements for such programs.

"(B) APPROVAL OF CERTAIN PROGRAMS.—Such requirements—

"(i) may permit approval of programs offered by or in facilities, as well as outside facilities (including employee organizations), and of programs in effect on the date of the enactment of this section;

"(ii) shall permit a State to find that an individual who has completed (before July 1, 1989) a nurse aide training and competency evaluation program shall be

deemed to have completed such a program approved under subsection (b)(5) if the State determines that, at the time the program was offered, the program met the requirements for approval under such paragraph; and

"(iii) shall prohibit approval of such a program—

"(I) offered by or in a skilled nursing facility which has been determined to be out of compliance with the requirements of subsection (b), (c), or (d), within the previous 2 years, or

"(II) offered by or in a skilled nursing facility unless the State makes the determination, upon an individual's completion of the program, that the individual is competent to provide nursing and nursing-related services in skilled nursing facilities.

A State may not delegate its responsibility under clause (iii)(II) to the skilled nursing facility.

"(3) FEDERAL GUIDELINES FOR STATE APPEALS PROCESS FOR TRANSFERS.—For purposes of subsections (c)(2)(B)(iii)(I) and (e)(3), by not later than October 1, 1989, the Secretary shall establish guidelines for minimum standards which State appeals processes under subsection (e)(3) must meet to provide a fair mechanism for hearing appeals on transfers of residents from skilled nursing facilities.

"(4) SECRETARIAL STANDARDS FOR QUALIFICATION OF ADMINISTRATORS.—For purposes of subsections (d)(1)(C) and (e)(4), the Secretary shall develop, by not later than March 1, 1989, standards to be applied in assuring the qualifications of administrators of skilled nursing facilities.

"(5) CRITERIA FOR ADMINISTRATION.—The Secretary shall establish criteria for assessing a skilled nursing facility's compliance with the requirement of subsection (d)(1) with respect to—

"(A) its governing body and management,

"(B) agreements with hospitals regarding transfers of residents to and from the hospitals and to and from other skilled nursing facilities,

"(C) disaster preparedness,

"(D) direction of medical care by a physician,

"(E) laboratory and radiological services,

"(F) clinical records, and

"(G) resident and advocate participation.

"(6) SPECIFICATION OF RESIDENT ASSESSMENT DATA SET AND INSTRUMENTS.—The Secretary shall—

"(A) not later than July 1, 1989, specify a minimum data set of core elements and common definitions for use by nursing facilities in conducting the assessments required under subsection (b)(3), and establish guidelines for utilization of the data set; and

"(B) by not later than October 1, 1990, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subsection (e)(5)(A) for use by nursing facilities in complying with the requirements of subsection (b)(3)(A)(iii).

"(7) LIST OF ITEMS AND SERVICES FURNISHED IN SKILLED NURSING FACILITIES NOT CHARGEABLE TO THE PERSONAL FUNDS OF A RESIDENT.—

"(A) REGULATIONS REQUIRED.—Pursuant to the requirement of section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, the Secretary shall issue regulations, on or before the first day of the seventh month to begin after the date of enactment of this section, that define those costs which may be charged to the personal funds of patients in skilled nursing facilities who are individuals receiving benefits under this part and those costs which are to be included in the reasonable cost (or other payment amount) under this title for extended care services.

"(B) RULE IF FAILURE TO PUBLISH REGULATIONS.—If the Secretary does not issue the regulations under subparagraph (A) on or before the date required in such subparagraph, in the case of a resident of a skilled nursing facility who is eligible to receive benefits under this part, the costs which may not be charged to the personal funds of such resident (and for which payment is considered to be made under this title) shall not include, at a minimum, the costs for routine personal hygiene items and services furnished by the facility.".

(b) COSTS OF MEETING REQUIREMENTS.—

(1) UNDER REASONABLE COST.—Section 1861(v)(1)(E) of such Act (42 U.S.C. 1395s(v)(1)(E)) is amended by adding at the end the following new sentence: "Notwithstanding the previous sentence, such regulations with respect to skilled nursing facilities shall take into account (in a manner consistent with subparagraph (A) and based on patient-days of services furnished) the costs of such facilities complying with the requirements of subsections (b), (c), and (d) of section 1819 (including the costs of conducting nurse aide training and competency evaluation programs and competency evaluation programs).".

(2) ADJUSTMENT IN PROSPECTIVE PAYMENTS.—Section 1888(d) of such Act (42 U.S.C. 1395yy(d)) is amended by adding at the end the following new paragraph:

"(7) In computing the rates of payment to be made under this subsection, there shall be taken into account the costs described in the last sentence of section 1861(v)(1)(E) (relating to compliance with nursing facility requirements and of conducting nurse aide training and competency evaluation programs and competency evaluation programs).".

(c) EVALUATION.—The Secretary of Health and Human Services shall evaluate, and report to Congress by not later than January 1, 1992, on the implementation of the resident assessment process for residents of skilled nursing facilities under the amendments made by this section.

(d) CONFORMING AMENDMENT.—Section 1861(a)(2) of the Social Security Act (42 U.S.C. 1395x(a)(2)) is amended by striking "skilled nursing facility" and inserting "facility described in section 1919(a)(2) or subsection (y)(1)".

SEC. 4202. SURVEY AND CERTIFICATION PROCESS.

(a) STATE REQUIREMENT FOR PROCESS.—Title XVIII of the Social Security Act is amended—

(1) in section 1864(d) (42 U.S.C. 1395aa(d)), as added by section 4201(a)(2) of this Act, by inserting before the period "and section 1819(g)", and

(2) in section 1819, as added by section 4201(a)(3) of this Act, by adding at the end the following new subsection:

"(g) SURVEY AND CERTIFICATION PROCESS.—

"(1) STATE AND FEDERAL RESPONSIBILITY.—

"(A) IN GENERAL.—Pursuant to an agreement under section 1864, each State shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of skilled nursing facilities (other than facilities of the State) with the requirements of subsections (b), (c), and (d). The Secretary shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of State skilled nursing facilities with the requirements of such subsections.

"(B) EDUCATIONAL PROGRAM.—Each State shall conduct periodic educational programs for the staff and residents (and their representatives) of skilled nursing facilities in order to present current regulations, procedures, and policies under this section.

"(C) INVESTIGATION OF ALLEGATIONS OF RESIDENT NEGLECT AND ABUSE AND MISAPPROPRIATION OF RESIDENT PROPERTY.—The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection, for a process for the receipt, review, and investigation of allegations of resident neglect and abuse and misappropriation of resident property by a nurse aide in a nursing facility. If the State finds, after notice to the nurse aide involved and a reasonable opportunity for a hearing for the nurse aide to rebut allegations, that a nurse aide whose name is contained in a nurse aide registry has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding.

"(D) CONSTRUCTION.—The failure of the Secretary to establish standards under subsection (f) shall not relieve a State of its responsibility under this subsection.

"(2) SURVEYS.—

"(A) STANDARD SURVEY.—

"(i) IN GENERAL.—Each skilled nursing facility shall be subject to a standard survey, to be conducted without any prior notice to the facility. Any individual who notifies (or causes to be notified) a skilled nursing facility of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The Secretary shall provide for imposition of civil money penalties under this clause in a manner similar to that for the imposition of civil money penalties under section 1128A. The Secretary shall review each State's procedures for the

scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

"(ii) CONTENTS.—Each standard survey shall include, for a case-mix stratified sample of residents—

"(I) a survey of the quality of care furnished, as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutrition services, activities and social participation, and sanitation, infection control, and the physical environment,

"(II) written plans of care provided under subsection (b)(2) and an audit of the residents' assessments under subsection (b)(3) to determine the accuracy of such assessments and the adequacy of such plans of care, and

"(III) a review of compliance with residents' rights under subsection (c).

"(iii) FREQUENCY.—

"(I) IN GENERAL.—Each skilled nursing facility shall be subject to a standard survey not later than 15 months after the date of the previous standard survey conducted under this subparagraph. The Statewide average interval between standard surveys of skilled nursing facilities under this subsection shall not exceed 12 months.

"(II) SPECIAL SURVEYS.—If not otherwise conducted under subclause (I), a standard survey (or an abbreviated standard survey) may be conducted within 2 months of any change of ownership, administration, management of a skilled nursing facility, or the director of nursing in order to determine whether the change has resulted in any decline in the quality of care furnished in the facility.

"(B) EXTENDED SURVEYS.—

"(i) IN GENERAL.—Each skilled nursing facility which is found, under a standard survey, to have provided substandard quality of care shall be subject to an extended survey. Any other facility may, at the Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey).

"(ii) TIMING.—The extended survey shall be conducted immediately after the standard survey (or, if not practical, not later than 2 weeks after the date of completion of the standard survey).

"(iii) CONTENTS.—In such an extended survey, the survey team shall review and identify the policies and procedures which produced such substandard quality of care and shall determine whether the facility has complied with all the requirements described in subsections (b), (c), and (d). Such review shall include an expansion of the size of the sample of residents' assessments reviewed and a review of the staffing, of in-serv-

ice training, and, if appropriate, of contracts with consultants.

"(iv) CONSTRUCTION.—Nothing in this paragraph shall be construed as requiring an extended or partial extended survey as a prerequisite to imposing a sanction against a facility under subsection (h) on the basis of findings in a standard survey.

"(C) SURVEY PROTOCOL.—Standard and extended surveys shall be conducted—

"(i) based upon a protocol which the Secretary has developed, tested, and validated by not later than October 1, 1990, and

"(ii) by individuals, of a survey team, who meet such minimum qualifications as the Secretary establishes by not later than such date.

The failure of the Secretary to develop, test, or validate such protocols or to establish such minimum qualifications shall not relieve any State of its responsibility (or the Secretary of the Secretary's responsibility) to conduct surveys under this subsection.

"(D) CONSISTENCY OF SURVEYS.—Each State and the Secretary shall implement programs to measure and reduce inconsistency in the application of survey results among surveyors.

"(E) SURVEY TEAMS.—

"(i) IN GENERAL.—Surveys under this subsection shall be conducted by a multidisciplinary team of professionals (including a registered professional nurse).

"(ii) PROHIBITION OF CONFLICTS OF INTEREST.—A State may not use as a member of a survey team under this subsection an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the facility surveyed respecting compliance with the requirements of subsections (b), (c), and (d), or who has a personal or familial financial interest in the facility being surveyed.

"(iii) TRAINING.—The Secretary shall provide for the comprehensive training of State and Federal surveyors in the conduct of standard and extended surveys under this subsection, including the auditing of resident assessments and plans of care. No individual shall serve as a member of a survey team unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary.

"(3) VALIDATION SURVEYS.——

"(A) IN GENERAL.—The Secretary shall conduct onsite surveys of a representative sample of skilled nursing facilities in each State, within 2 months of the date of surveys conducted under paragraph (2) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under paragraph (2). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under paragraph

(2). If the State has determined that an individual skilled nursing facility meets the requirements of subsections (b), (c), and (d), but the Secretary determines that the facility does not meet such requirements, the Secretary's determination as to the facility's noncompliance with such requirements is binding and supersedes that of the State survey.

"(B) SCOPE.—With respect to each State, the Secretary shall conduct surveys under subparagraph (A) each year with respect to at least 5 percent of the number of skilled nursing facilities surveyed by the State in the year, but in no case less than 5 skilled nursing facilities in the State.

"(C) REMEDIES FOR SUBSTANDARD PERFORMANCE.—If the Secretary finds, on the basis of such surveys, that a State has failed to perform surveys as required under paragraph (2) or that a State's survey and certification performance otherwise is not adequate, the Secretary shall provide for an appropriate remedy, which may include the training of survey teams in the State.

"(C) SPECIAL SURVEYS OF COMPLIANCE.—Where the Secretary has reason to question the compliance of a skilled nursing facility with any of the requirements of subsections (b), (c), and (d), the Secretary may conduct a survey of the facility and, on that basis, make independent and binding determinations concerning the extent to which the skilled nursing facility meets such requirements.

"(4) INVESTIGATION OF COMPLAINTS AND MONITORING COMPLIANCE.—Each State shall maintain procedures and adequate staff to—

"(A) investigate complaints of violations of requirements by skilled nursing facilities, and

"(B) monitor, on-site, on a regular, as needed basis, a skilled nursing facility's compliance with the requirements of subsections (b), (c), and (d), if—

"(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

"(ii) the facility was previously found not to be in compliance with such requirements, has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

"(iii) the State has reason to question the compliance of the facility with such requirements.

A State may maintain and utilize a specialized team (including an attorney, an auditor, and appropriate health care professionals) for the purpose of identifying, surveying, gathering and preserving evidence, and carrying out appropriate enforcement actions against chronically substandard skilled nursing facilities.

"(5) DISCLOSURE OF RESULTS OF INSPECTIONS AND ACTIVITIES.—

"(A) PUBLIC INFORMATION.—Each State, and the Secretary, shall make available to the public—

"(i) information respecting all surveys and certifications made respecting skilled nursing facilities, including statements of deficiencies and plans of correction,

"(ii) copies of cost reports of such facilities filed under this title or title XIX,

"(iii) copies of statements of ownership under section 1124, and

"(iv) information disclosed under section 1126.

"(B) NOTICE TO OMBUDSMAN.— Each State shall notify the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) of the State's findings of noncompliance with any of the requirements of subsections (b), (c), and (d), with respect to a skilled nursing facility in the State.

"(C) NOTICE TO PHYSICIANS AND SKILLED NURSING FACILITY ADMINISTRATOR LICENSING BOARD.—If a State finds that a skilled nursing facility has provided substandard quality of care, the State shall notify—

"(i) the attending physician of each resident with respect to which such finding is made, and

"(ii) the State board responsible for the licensing of the skilled nursing facility administrator at the facility.

"(C) ACCESS TO FRAUD CONTROL UNITS.—Each State shall provide its State medicaid fraud and abuse control unit (established under section 1903(q)) with access to all information of the State agency responsible for surveys and certifications under this subsection.".

(c) POSTING SURVEY RESULTS.—Section 1864(a) of such Act (42 U.S.C. 1395aa(a)) is amended by inserting, after "readily available form and place" in the fifth sentence, the following: ", and require (in the case of skilled nursing facilities) the posting in a place readily accessible to patients (and patients' representatives),".

SEC. 4203. ENFORCEMENT PROCESS.

(a) STATE REQUIREMENT.—Title XVIII of the Social Security Act is amended—

(1) in section 1864(d) (42 U.S.C. 1395aa(d)), as added by section 4201(a)(2) and as amended by section 4202(a)(1) of this Act, by inserting before the period at the end the following: "and the establishment of remedies under sections 1819(h)(2)(B) and 1819(h)(2)(C) (relating to establishment and application of remedies)"; and

(2) by adding at the end of section 1819 of such Act, as added by section 4201(a)(3) and as amended by section 4202(a)(2), the end the following new subsection:

"(h) ENFORCEMENT PROCESS.—

"(1) IN GENERAL.—If a State finds, on the basis of a standard, extended, or partial extended survey under subsection (g)(2) or otherwise, that a skilled nursing facility no longer meets a requirement of subsection (b), (c), or (d), and further finds that the facility's deficiencies—

"(A) immediately jeopardize the health or safety of its residents, the State shall recommend to the Secretary that the Secretary take such action as described in paragraph (2)(A)(i); or

"(B) do not immediately jeopardize the health or safety of its residents, the State may recommend to the Secretary that the Secretary take such action as described in paragraph (2)(A)(ii).

If a State finds that a skilled nursing facility meets the requirements of subsections (b), (c), and (d), but, as of a previous period, did not meet such requirements, the State may recommend a civil money penalty under paragraph (2)(B)(ii) for the days in which it finds that the facility was not in compliance with such requirements.

"(2) SECRETARIAL AUTHORITY.—

"(A) IN GENERAL.—With respect to any skilled nursing facility in a State, if the Secretary finds, or pursuant to a recommendation of the State under paragraph (1) finds, that a skilled nursing facility no longer meets a requirement of subsection (b), (c), or (d), and further finds that the facility's deficiencies—

"(i) immediately jeopardize the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subparagraph (B)(iii), or terminate the facility's participation under this title and may provide, in addition, for one or more of the other remedies described in subparagraph (B); or

"(ii) do not immediately jeopardize the health or safety of its residents, the Secretary may impose any of the remedies described in subparagraph (B).

Nothing in this subparagraph shall be construed as restricting the remedies available to the Secretary to remedy a skilled nursing facility's deficiencies. If the Secretary finds, or pursuant to the recommendation of the State under paragraph (1) finds, that a skilled nursing facility meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (B)(ii) for the days on which he finds that the facility was not in compliance with such requirements.

"(B) SPECIFIED REMEDIES.—The Secretary may take the following actions with respect to a finding that a facility has not met an applicable requirement:

"(i) DENIAL OF PAYMENT.—The Secretary may deny any further payments under this title with respect to all individuals entitled to benefits under this title in the facility or with respect to such individuals admitted to the facility after the effective date of the finding.

"(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—The Secretary may impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance and the Secretary shall impose and collect such a penalty in the same manner as civil money penalties are imposed and collected under section 1128A.

"(iii) APPOINTMENT OF TEMPORARY MANAGEMENT.—In consultation with the State, the Secretary may ap-

point temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

"(I) there is an orderly closure of the facility, or

"(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d).

The temporary management under this clause shall not be terminated under subclause (II) until the Secretary has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d).

The Secretary shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the Secretary may provide for other specified remedies, such as directed plans of correction.

"(C) CONTINUATION OF PAYMENTS PENDING REMEDIATION.—The Secretary may continue payments, over a period of not longer than 6 months, under this title with respect to a skilled nursing facility not in compliance with a requirement of subsection (b), (c), or (d), if—

"(i) the State survey agency finds that it is more appropriate to take alternative action to assure compliance of the facility with the requirements than to terminate the certification of the facility,

"(ii) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

"(iii) the facility agrees to repay to the Federal Government payments received under this subparagraph if the corrective action is not taken in accordance with the approved plan and timetable.

The Secretary shall establish guidelines for approval of corrective actions requested by States under this subparagraph.

"(D) ASSURING PROMPT COMPLIANCE.—If a skilled nursing facility has not complied with any of the requirements of subsections (b), (c), and (d), within 3 months after the date the facility is found to be out of compliance with such requirements, the Secretary shall impose the remedy described in subparagraph (B)(i) for all individuals who are admitted to the facility after such date.

"(E) REPEATED NONCOMPLIANCE.—In the case of a skilled nursing facility which, on 3 consecutive standard surveys conducted under subsection (g)(2), has been found to have provided substandard quality of care, the Secretary shall (regardless of what other remedies are provided)—

"(i) impose the remedy described in subparagraph (B)(i), and

"(ii) monitor the facility under subsection (g)(4)(B),

until the facility has demonstrated, to the satisfaction of the Secretary, that it is in compliance with the requirements of subsections (b), (c), and (d), and that it will remain in compliance with such requirements.

"(3) EFFECTIVE PERIOD OF DENIAL OF PAYMENT.—A finding to deny payment under this subsection shall terminate when the Secretary finds that the facility is in substantial compliance with all the requirements of subsections (b), (c), and (d).

"(4) IMMEDIATE TERMINATION OF PARTICIPATION FOR FACILITY WHERE SECRETARY FINDS NONCOMPLIANCE AND IMMEDIATE JEOPARDY.—If the Secretary finds that a skilled nursing facility has not met a requirement of subsection (b), (c), or (d), and finds that the failure immediately jeopardizes the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(B)(iii), or the Secretary shall terminate the facility's participation under this title. If the facility's participation under this title is terminated, the State shall provide for the safe and orderly transfer of the residents eligible under this title consistent with the requirements of subsection (c)(2).

"(5) CONSTRUCTION.—The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law. The remedies described in clauses (i), (iii), and (iv) of paragraph (2)(A) may be imposed during the pendency of any hearing.

"(6) SHARING OF INFORMATION.—Notwithstanding any other provision of law, all information concerning skilled nursing facilities required by this section to be filed with the Secretary or a State agency shall be made available to Federal or State employees for purposes consistent with the effective administration of programs established under this title and title XIX, including investigations by State medicaid fraud control units.".

SEC. 4204. EFFECTIVE DATES.

(a) NEW REQUIREMENTS AND SURVEY AND CERTIFICATION PROCESS.—Except as otherwise specifically provided in section 1819 of the Social Security Act, the amendments made by this part shall apply to extended care services furnished on or after October 1, 1990, without regard to whether regulations to implement such amendments are promulgated by such date.

(b) WAIVER OF PAPERWORK REDUCTION.—Chapter 35 of title 44, United States Code, shall not apply to information required for purposes of carrying out this part and implementing the amendments made by this part.

SEC. 4205. ANNUAL REPORT.

The Secretary of Health and Human Services shall report to the Congress annually on the extent to which skilled nursing facilities are complying with the requirements of subsections (b), (c), and (d)

of section 1819 of the Social Security Act (as added by the amendments made by this part) and the number and type of enforcement actions taken by States and the Secretary under section 1819(h) of such Act (as added by section 4203 of this Act).

SEC. 4206. CONSTRUCTION.

Section 1819 of the Social Security Act is amended by adding at the end the following new subsection:

"(i) CONSTRUCTION.—Where requirements or obligations under this section are identical to those provided under section 1919 of this Act, the fulfillment of those requirements or obligations under section 1919 shall be considered to be the fulfillment of the corresponding requirements or obligations under this section.".

PART 2—MEDICAID PROGRAM

SEC. 4211. REQUIREMENTS FOR NURSING FACILITIES.

(a) SPECIFICATION OF FACILITY REQUIREMENTS.—Title XIX of the Social Security Act is amended—

(1) by redesignating section 1922 as section 1923,

(2) by redesignating section 1919 as section 1922 and by transferring and inserting such section after section 1921, and

(3) by inserting after section 1918 the following new section:

"REQUIREMENTS FOR NURSING FACILITIES

"SEC. 1919. (a) NURSING FACILITY DEFINED.—In this title, the term 'nursing facility' means an institution (or a distinct part of an institution) which—

"(1) is primarily engaged in providing to residents—

"(A) skilled nursing care and related services for residents who require medical or nursing care,

"(B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, or

"(C) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities,

and is not primarily for the care and treatment of mental diseases;

"(2) has in effect a transfer agreement (meeting the requirements of section 1861(l)) with one or more hospitals having agreements in effect under section 1866; and

"(3) meets the requirements for a nursing facility described in subsections (b), (c), and (d) of this section.

Such term also includes any facility which is located in a State on an Indian reservation and is certified by the Secretary as meeting the requirements of paragraph (1) and subsections (b), (c), and (d).

"(b) REQUIREMENTS RELATING TO PROVISION OF SERVICES.—

"(1) QUALITY OF LIFE.—

"(A) IN GENERAL.—A nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

"(B) QUALITY ASSESSMENT AND ASSURANCE.—A nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies.

"(2) SCOPE OF SERVICES AND ACTIVITIES UNDER PLAN OF CARE.—A nursing facility must provide services and activities to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care which—

"(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

"(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

"(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

"(3) RESIDENTS' ASSESSMENT.—

"(A) REQUIREMENT.—A nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—

"(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;

"(ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A);

"(iii) in the case of a resident eligible for benefits under this title, uses an instrument which is specified by the State under subsection (e)(5); and

"(iv) in the case of a resident eligible for benefits under part A of title XVIII, includes the identification of medical problems.

"(B) CERTIFICATION.—

"(i) IN GENERAL.—Each such assessment must be conducted or coordinated (with the appropriate participation of health professionals) by a registered professional nurse who signs and certifies the completion of the assessment. Each individual who completes a portion of such an assessment shall sign and certify as to the accuracy of that portion of the assessment.

"(ii) PENALTY FOR FALSIFICATION.—

"(I) An individual who willfully and knowingly certifies under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 with respect to each assessment.

"(II) An individual who willfully and knowingly causes another individual to certify under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 with respect to each assessment.

"(III) The Secretary shall provide for imposition of civil money penalties under this clause in a manner similar to that for the imposition of civil money penalties under section 1128A.

"(iii) USE OF INDEPENDENT ASSESSORS.—If a State determines, under a survey under subsection (g) or otherwise, that there has been a knowing and willful certification of false assessments under this paragraph, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the State.

"(C) FREQUENCY.—

"(i) IN GENERAL.—Such an assessment must be conducted—

"(I) promptly upon (but no later than 4 days after the date of) admission for each individual admitted on or after October 1, 1990, and by not later than October 1, 1991, for each resident of the facility on that date;

"(II) promptly after a significant change in the resident's physical or mental condition; and

"(III) in no case less often than once every 12 months.

"(ii) RESIDENT REVIEW.—The nursing facility must examine each resident no less frequently than once every 3 months and, as appropriate, revise the resident's assessment to assure the continuing accuracy of the assessment.

"(D) USE.—The results of such an assessment shall be used in developing, reviewing, and revising the resident's plan of care under paragraph (2).

"(E) COORDINATION.—Such assessments shall be coordinated with any State-required preadmission screening program to the maximum extent practicable in order to avoid duplicative testing and effort.

"(F) REQUIREMENTS RELATING TO PREADMISSION SCREENING FOR MENTALLY ILL AND MENTALLY RETARDED INDIVIDUALS.—A nursing facility must not admit, on or after January 1, 1989, any new resident who—

"(i) is mentally ill (as defined in subsection (e)(7)(G)(i)) unless the State mental health authority has determined (based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority) prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether

the individual requires active treatment for mental illness, or

"(ii) is mentally retarded (as defined in subsection (e)(7)(G)(ii)) unless the State mental retardation or developmental disability authority has determined prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires active treatment for mental retardation.

"(4) PROVISION OF SERVICES AND ACTIVITIES.—

"(A) IN GENERAL.—To the extent needed to fulfill all plans of care described in paragraph (2), a nursing facility must provide (or arrange for the provision of)—

"(i) nursing and related services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

"(ii) medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

"(iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident;

"(iv) dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident;

"(v) an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident; and

"(vi) routine dental services (to the extent covered under the State plan) and emergency dental services to meet the needs of each resident.

The services provided or arranged by the facility must meet professional standards of quality.

"(B) QUALIFIED PERSONS PROVIDING SERVICES.—Services described in clauses (i), (ii), (iii), (iv), and (vi) of subparagraph (A) must be provided by qualified persons in accordance with each resident's written plan of care.

"(C) REQUIRED NURSING CARE; FACILITY WAIVERS.—

"(i) GENERAL REQUIREMENTS.—With respect to nursing facility services provided on or after October 1, 1990, a nursing facility—

"(I) except as provided in clause (ii), must provide 24-hour licensed nursing services which are sufficient to meet the nursing needs of its residents, and

"(II) except as provided in clause (ii), must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

"(ii) FACILITY WAIVERS.—

"(i) WAIVER BY STATE.—A State may waive the requirement of subclause (I) or (II) of clause (i) with respect to a facility if—

"(I) the facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel,

"(II) the State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility, and

"(III) the State finds that, for any such periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility.

A waiver under this clause shall be subject to annual review and to the review of the Secretary and subject to clause (ii) shall be accepted by the Secretary for purposes of this title to the same extent as is the State's certification of the facility. In granting or renewing a waiver, a State may require the facility to employ other qualified, licensed personnel.

"(ii) ASSUMPTION OF WAIVER AUTHORITY BY SECRETARY.—If the Secretary determines that a State has shown a clear pattern and practice of allowing waivers in the absence of diligent efforts by facilities to meet the staffing requirements, the Secretary shall assume and excercise the authority of the State to grant waivers.

"(5) REQUIRED TRAINING OF NURSE AIDES.—

"(A) IN GENERAL.—A nursing facility must not use (on a full-time, temporary, per diem, or other basis) any individual, who is not a licensed health professional (as defined in subparagraph (E)), as a nurse aide in the facility on or after January 1, 1990, for more than 4 months unless the individual—

"(i) has completed a training and competency evaluation program, or a competency evaluation program, approved by the State under subsection (e)(1)(A), and

"(ii) is competent to provide such services.

"(B) OFFERING COMPETENCY EVALUATION PROGRAMS FOR CURRENT EMPLOYEES.—A nursing facility must provide, for individuals used as a nurse aide by the facility as of July 1, 1989, for a competency evaluation program approved by the State under subsection (e)(1) and such preparation as may be necessary for the individual to complete such a program by January 1, 1990.

"(C) COMPETENCY.—The nursing facility must not permit an individual, other than in a training and competency evaluation program or a competency evaluation program approved by the State, to serve as a nurse aide or provide services of a type for which the individual has not demonstrated competency and must not use such an individual as

a nurse aide unless the facility has inquired of the State registry established under subsection (e)(2)(A) as to information in the registry concerning the individual.

"(D) RE-TRAINING REQUIRED.—For purposes of subparagraph (A), if, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual performed nursing or nursing-related services for monetary compensation, such individual shall complete a new training and competency evaluation program.

"(E) REGULAR IN-SERVICE EDUCATION.—The nursing facility must provide such regular performance review and regular in-service education as assures that individuals used as nurse aides are competent to perform services as nurse aides, including training for individuals providing nursing and nursing-related services to residents with cognitive impairments.

"(F) NURSE AIDE DEFINED.—In this paragraph, the term 'nurse aide' means any individual providing nursing or nursing-related services to residents in a nursing facility, but does not include an individual—

"(i) who is a licensed health professional (as defined in subparagraph (G)), or

"(ii) who volunteers to provide such services without monetary compensation.

"(G) LICENSED HEALTH PROFESSIONAL DEFINED.—In this paragraph, the term 'licensed health professional' means a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapist, registered professional nurse, licensed practical nurse, or licensed or certified social worker.

"(6) PHYSICIAN SUPERVISION AND CLINICAL RECORDS.—A nursing facility must—

"(A) require that the health care of every resident be provided under the supervision of a physician;

"(B) provide for having a physician available to furnish necessary medical care in case of emergency; and

"(C) maintain clinical records on all residents, which records include the plans of care (described in paragraph (2)) and the residents' assessments (described in paragraph (3)), as well as the results of any pre-admission screening conducted under subsection (e)(7).

"(7) REQUIRED SOCIAL SERVICES.—In the case of a nursing facility with more than 120 beds, the facility must have at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications) employed full-time to provide or assure the provision of social services.

"(c) REQUIREMENTS RELATING TO RESIDENTS' RIGHTS.—

"(1) GENERAL RIGHTS.—

"(A) SPECIFIED RIGHTS.—A nursing facility must protect and promote the rights of each resident, including each of the following rights:

"(i) FREE CHOICE.—The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

"(ii) FREE FROM RESTRAINTS.—The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed—

"(I) to ensure the physical safety of the resident or other residents, and

"(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except in emergency circumstances specified by the Secretary) until such an order could reasonably be obtained.

"(iii) PRIVACY.—The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups.

"(iv) CONFIDENTIALITY.—The right to confidentiality of personal and clinical records.

"(v) ACCOMMODATION OF NEEDS.—The right—

"(I) to reside and receive services with reasonable accommodations of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered, and

"(II) to receive notice before the room or roommate of the resident in the facility is changed.

"(vi) GRIEVANCES.—The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

"(vii) PARTICIPATION IN RESIDENT AND FAMILY GROUPS.—The right of the resident to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.

"(ix) PARTICIPATION IN OTHER ACTIVITIES.—The right of the resident to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

"(x) EXAMINATION OF SURVEY RESULTS.—The right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Sec-

retary or a State with respect to the facility and any plan of correction in effect with respect to the facility.

"(xi) OTHER RIGHTS.—Any other right established by the Secretary.

Clause (iii) shall not be construed as requiring the provision of a private room.

"(B) NOTICE OF RIGHTS.—A nursing facility must—

"(i) inform each resident, orally and in writing at the time of admission to the facility, of the resident's legal rights during the stay at the facility;

"(ii) make available to each resident, upon reasonable request, a written statement of such rights (which statement is updated upon changes in such rights);

"(iii) inform each resident who is entitled to medical assistance under this title—

"(I) at the time of admission to the facility or, if later, at the time the resident becomes eligible for such assistance, of the items and services (including those specified under section 1902(a)(28)(B)) that are included in nursing facility services under the State plan and for which the resident may not be charged (except as permitted in section 1916), and of those other items and services that the facility offers and for which the resident may be charged and the amount of the charges for such items and services, and

"(II) of changes in the items and services described in subclause (I) and of changes in the charges imposed for items and services described in that subclause; and

"(iv) inform each other resident, in writing before or at the time of admission and periodically during the resident's stay, of services available in the facility and of related charges for such services, including any charges for services not covered under title XVIII or by the facility's basic per diem charge.

The written description of legal rights under this subparagraph shall include a description of the protection of personal funds under paragraph (6) and a statement that a resident may file a complaint with a State survey and certification agency respecting resident abuse and neglect and misappropriation of resident property in the facility.

"(C) RIGHTS OF INCOMPETENT RESIDENTS.—In the case of a resident adjudged incompetent under the laws of a State, the rights of the resident under this title shall devolve upon, and, to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the resident's behalf.

"(D) USE OF PSYCHOPHARMACOLOGIC DRUGS.—Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the written plan of care described in paragraph (2)) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually an independent,

external consultant reviews the appropriateness of the drug plan of each resident receiving such drugs.

"(2) TRANSFER AND DISCHARGE RIGHTS.—

"(A) IN GENERAL.—A nursing facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless—

"(i) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;

"(ii) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

"(iii) the safety of individuals in the facility is endangered;

"(iv) the health of individuals in the facility would otherwise be endangered;

"(v) the resident has failed, after reasonable and appropriate notice, to pay (or to have paid under this title or title XVIII on the resident's behalf) an allowable charge imposed by the facility for an item or service requested by the resident and for which a charge may be imposed consistent with this title and title XVIII; or

"(vi) the facility ceases to operate.

In each of the cases described in clauses (i) through (v), the basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in clauses (i) and (ii), the documentation must be made by the resident's physician, and in the case described in clause (iv) the documentation must be made by a physician. For purposes of clause (v), in the case of a resident who becomes eligible for assistance under this title after admission to the facility, only charges which may be imposed under this title shall be considered to be allowable.

"(B) PRE-TRANSFER AND PRE-DISCHARGE NOTICE.—

"(i) IN GENERAL.—Before effecting a transfer or discharge of a resident, a nursing facility must—

"(I) notify the resident (and, if known, a family member of the resident or legal representative) of the transfer or discharge and the reasons therefor,

"(II) record the reasons in the resident's clinical record (including any documentation required under subparagraph (A)), and

"(III) include in the notice the items described in clause (iii).

"(ii) TIMING OF NOTICE.—The notice under clause (i)(I) must be made at least 30 days in advance of the resident's transfer or discharge except—

"(I) in a case described in clause (iii) or (iv) of subparagraph (A);

"(II) in a case described in clause (ii) of subparagraph (A), where the resident's health improves sufficiently to allow a more immediate transfer or discharge;

"(III) in a case described in clause (i) of subparagraph (A), where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs; or

"(IV) in a case where a resident has not resided in the facility for 30 days.

In the case of such exceptions, notice must be given as many days before the date of the transfer or discharge as is practicable.

"(iii) ITEMS INCLUDED IN NOTICE.—Each notice under clause (i) must include—

"(I) for transfers or discharges effected on or after October 1, 1989, notice of the resident's right to appeal the transfer or discharge under the State process established under subsection (e)(3);

"(II) the name, mailing address, and telephone number of the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965);

"(III) in the case of residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals established under part C of the Developmental Disabilities Assistance and Bill of Rights Act; and

"(IV) in the case of mentally ill residents (as defined in subsection (e)(7)(G)(i)), the mailing address and telephone number of the agency responsible for the protection and advocacy system for mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.

"(C) ORIENTATION.—A nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

"(D) NOTICE ON BED-HOLD POLICY AND READMISSION.—

"(i) NOTICE BEFORE TRANSFER.—Before a resident of a nursing facility is transferred for hospitalization or therapeutic leave, a nursing facility must provide written information to the resident and a family member or legal representative concerning—

"(I) the provisions of the State plan under this title regarding the period (if any) during which the resident will be permitted under the State plan to return and resume residence in the facility, and

"(II) the policies of the facility regarding such a period, which policies must be consistent with clause (iii).

"(ii) NOTICE UPON TRANSFER.—At the time of transfer of a resident to a hospital or for therapeutic leave, a nursing facility must provide written notice to the resident and a family member or legal representative of the duration of any period described in clause (i).

"(iii) PERMITTING RESIDENT TO RETURN.—A nursing facility must establish and follow a written policy under which a resident—

"(I) who is eligible for medical assistance for nursing facility services under a State plan,

"(II) who is transferred from the facility for hospitalization or therapeutic leave, and

"(III) whose hospitalization or therapeutic leave exceeds a period paid for under the State plan for the holding of a bed in the facility for the resident,

will be permitted to be readmitted to the facility immediately upon the first availability of a bed in a semi-private room in the facility if, at the time of readmission, the resident requires the services provided by the facility.

"(3) ACCESS AND VISITATION RIGHTS.—A nursing facility must—

"(A) permit immediate access to any resident by any representative of the Secretary, by any representative of the State, by an ombudsman or agency described in subclause (II), (III), or (IV) of paragraph (2)(B)(iii), or by the resident's individual physician;

"(B) permit immediate access to a resident, subject to the resident's right to deny or withdraw consent at any time, by immediate family or other relatives of the resident;

"(C) permit immediate access to a resident, subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, by others who are visiting with the consent of the resident;

"(D) permit reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and

"(E) permit representatives of the State ombudsman (described in paragraph (2)(B)(iii)(II)), with the permission of the resident (or the resident's legal representative) and consistent with State law, to examine a resident's clinical records.

"(4) EQUAL ACCESS TO QUALITY CARE.—

"(A) IN GENERAL.—A nursing facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services required under the State plan for all individuals regardless of source of payment.

"(B) CONSTRUCTION.—

"(i) NOTHING PROHIBITING ANY CHARGES FOR NON-MEDICAID PATIENTS.—Subparagraph (A) shall not be construed as prohibiting a nursing facility from charging any amount for services furnished, consistent with the notice in paragraph (1)(B) describing such charges.

"(ii) NO ADDITIONAL SERVICES REQUIRED.—Subparagraph (A) shall not be construed as requiring a State to offer additional services on behalf of a resident than are otherwise provided under the State plan.

"(5) ADMISSIONS POLICY.—

"(A) ADMISSIONS.—With respect to admissions practices, a nursing facility must—

"(i)(I) not require individuals applying to reside or residing in the facility to waive their rights to benefits under this title or title XVIII, (II) not require oral or written assurance that such individuals are not eligible for, or will not apply for, benefits under this title or title XVIII, and (III) prominently display in the facility written information, and provide to such individuals oral and written information, about how to apply for and use such benefits and how to receive refunds for previous payments covered by such benefits;

"(ii) not require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility; and

"(iii) in the case of an individual who is entitled to medical assistance for nursing facility services, not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan under this title, any gift, money, donation, or other consideration as a precondition of admitting (or expediting the admission of) the individual to the facility or as a requirement for the individual's continued stay in the facility.

"(B) CONSTRUCTION.—

"(i) NO PREEMPTION OF STRICTER STANDARDS.—Subparagraph (A) shall not be construed as preventing States or political subdivisions therein from prohibiting, under State or local law, the discrimination against individuals who are entitled to medical assistance under the State plan with respect to admissions practices of nursing facilities.

"(ii) CONTRACTS WITH LEGAL REPRESENTATIVES.—Subparagraph (A)(ii) shall not be construed as preventing a facility from requiring an individual, who has legal access to a resident's income or resources available to pay for care in the facility, to sign a contract (without incurring personal financial liability) to provide payment from the resident's income or resources for such care.

"(iii) CHARGES FOR ADDITIONAL SERVICES REQUESTED.—Subparagraph (A)(iii) shall not be construed as preventing a facility from charging a resident, eligible for medical assistance under the State plan, for items or services the resident has requested and received and that are not specified in the State plan as included in the term 'nursing facility services'.

"(iv) BONA FIDE CONTRIBUTIONS.—Subparagraph (A)(iii) shall not be construed as prohibiting a nursing facility from soliciting, accepting, or receiving a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the resident (or potential resident), but only to the extent that such

contribution is not a condition of admission, expediting admission, or continued stay in the facility.

"(6) PROTECTION OF RESIDENT FUNDS.—

"(A) IN GENERAL.—The nursing facility—

"(i) may not require residents to deposit their personal funds with the facility, and

"(ii) once the facility accepts the written authorization of the resident, must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this paragraph.

"(B) MANAGEMENT OF PERSONAL FUNDS.—Upon a facility's acceptance of written authorization of a resident under subparagraph (A)(ii), the facility must manage and account for the personal funds of the resident deposited with the facility as follows:

"(i) DEPOSIT.—The facility must deposit any amount of personal funds in excess of $50 with respect to a resident in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the facility must maintain such funds in a non-interest bearing account or petty cash fund.

"(ii) ACCOUNTING AND RECORDS.—The facility must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a resident deposited with the facility, and afford the resident (or a legal representative of the resident) reasonable access to such record.

"(iii) NOTICE OF CERTAIN BALANCES.—The facility must notify each resident receiving medical assistance under the State plan under title XIX when the amount in the resident's account reaches $200 less than the dollar amount determined under section 1611(a)(3)(B) and the fact that if the amount in the account (in addition to the value of the resident's other nonexempt resources) reaches the amount determined under such section the resident may lose eligibility for such medical assistance or for benefits under title XVI.

"(iv) CONVEYANCE UPON DEATH.—Upon the death of a resident with such an account, the facility must convey promptly the resident's personal funds (and a final accounting of such funds) to the individual administering the resident's estate.

"(C) ASSURANCE OF FINANCIAL SECURITY.—The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

"(D) LIMITATION ON CHARGES TO PERSONAL FUNDS.—The facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made under this title or title XVIII.

"(d) REQUIREMENTS RELATING TO ADMINISTRATION AND OTHER MATTERS.—

"(1) ADMINISTRATION.—

"(A) IN GENERAL.—A nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident (consistent with requirements established under subsection (f)(5)).

"(B) REQUIRED NOTICES.—If a change occurs in—

"(i) the persons with an ownership or control interest (as defined in section 1124(a)(3)) in the facility,

"(ii) the persons who are officers, directors, agents, or managing employees (as defined in section 1126(b)) of the facility,

"(iii) the corporation, association, or other company responsible for the management of the facility, or

"(iv) the individual who is the administrator or director of nursing of the facility,

the nursing facility must provide notice to the State agency responsible for the licensing of the facility, at the time of the change, of the change and of the identity of each new person, company, or individual described in the respective clause.

"(C) NURSING FACILITY ADMINISTRATOR.—The administrator of a nursing facility must meet standards established by the Secretary under subsection (f)(4).

"(2) LICENSING AND LIFE SAFETY CODE.—

"(A) LICENSING.—A nursing facility must be licensed under applicable State and local law.

"(B) LIFE SAFETY CODE.—A nursing facility must meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes; except that—

"(i) the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a facility, but only if such waiver would not adversely affect the health and safety of residents or personnel, and

"(ii) the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects residents of and personnel in nursing facilities.

"(3) SANITARY AND INFECTION CONTROL AND PHYSICAL ENVIRONMENT.—A nursing facility must—

"(A) establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection, and

"(B) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents, personnel, and the general public.

"(4) MISCELLANEOUS.—

"(A) COMPLIANCE WITH FEDERAL, STATE, AND LOCAL LAWS AND PROFESSIONAL STANDARDS.—A nursing facility must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations (including the requirements of section 1124 and with accepted professional standards and principles which apply to professionals providing services in such a facility.

"(B) OTHER.—A nursing facility must meet such other requirements relating to the health and safety of residents or relating to the physical facilities thereof as the Secretary may find necessary.".

(c) STATE REQUIREMENTS RELATING TO NURSING FACILITY REQUIREMENTS.—Section 1919 of such Act is further amended by adding at the end the following new subsection:

"(e) STATE REQUIREMENTS RELATING TO NURSING FACILITY REQUIREMENTS.—As a condition of approval its plan under this title, a State must provide for the following:

"(1) SPECIFICATION AND REVIEW OF NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS AND OF NURSE AIDE COMPETENCY EVALUATION PROGRAMS.—The State must—

"(A) by not later than September 1, 1988, specify those training and competency evaluation programs, and those competency evaluation programs, that the State approves for purposes of subsection (b)(5) and that meet the requirements established under clause (i) or (ii) of subsection (f)(2)(A), and

"(B) by not later than September 1, 1990, provide for the review and reapproval of such programs, at a frequency and using a methodology consistent with the requirements established under subsection (f)(2)(A)(iii).

The failure of the Secretary to establish requirements under subsection (f)(2) shall not relieve any State of its responsibility under this paragraph.

"(2) NURSE AIDE REGISTRY.—

"(A) IN GENERAL.—By not later than January 1, 1989, the State shall establish and maintain a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program, or a nurse aide competency evaluation program, approved under paragraph (1) in the State.

"(B) INFORMATION IN REGISTRY.—The registry under subparagraph (A) shall provide (in accordance with regulations of the Secretary) for the inclusion of specific documented findings by a State under subsection (g)(1)(C) of resident neglect or abuse or misappropriation of resident property involving an individual listed in the registry, as well as any brief statement of the individual disputing the findings. In the case of inquiries to the registry concerning an individual listed in the registry, any information disclosed concerning such a finding shall also include disclosure of

any such statement in the registry relating to the finding or a clear and accurate summary of such a statement.

"(3) STATE APPEALS PROCESS FOR TRANSFERS.—The State, for transfers from nursing facilities effected on or after October 1, 1989, must provide for a fair mechanism, meeting the guidelines established under subsection (f)(3), for hearing appeals on transfers of residents of such facilities; but the failure of the Secretary to establish such guidelines under such subsection shall not relieve any State of its responsibility under this paragraph.

"(4) NURSING FACILITY ADMINISTRATOR STANDARDS.—By not later than July 1, 1989, the State must have implemented and enforced the nursing facility administrator standards developed under subsection (f)(4) respecting the qualification of administrators of nursing facilities.

"(5) SPECIFICATION OF RESIDENT ASSESSMENT INSTRUMENT.—Effective July 1, 1990, the State shall specify the instrument to be used by nursing facilities in the State in complying with the requirement of subsection (b)(3)(A)(iii). Such instrument shall be—

"(A) one of the instruments designated under subsection (f)(6)(B), or

"(B) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary under subsection (f)(6)(A).

"(6) NOTICE OF MEDICAID RIGHTS.—Each State, as a condition of approval of its plan under this title, effective April 1, 1988, must develop (and periodically update) a written notice of the rights and obligations of residents of nursing facilities (and spouses of such residents) under this title.

"(7) STATE REQUIREMENTS FOR PREADMISSION SCREENING AND RESIDENT REVIEW.—

"(A) PREADMISSION SCREENING.—Effective January 1, 1989, the State must have in effect a preadmission screening program, for making determinations (using any criteria developed under subsection (f)(8)) described in subsection (b)(3)(F) for mentally ill and mentally retarded individuals (as defined in subparagraph (G)) who are admitted to nursing facilities on or after January 1, 1989. The failure of the Secretary to develop minimum criteria under subsection (f)(8) shall not relieve any State of its responsibility to have a preadmission screening program under this subparagraph or to perform resident reviews under subparagraph (B).

"(B) STATE REQUIREMENT FOR ANNUAL RESIDENT REVIEW.—

"(i) FOR MENTALLY ILL RESIDENTS.—As of April 1, 1990, in the case of each resident of a nursing facility who is mentally ill, the State mental health authority must review and determine (using any criteria developed under subsection (f)(8) and based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority)—

"(I) whether or not the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility or requires the level of services of an inpatient psychiatric hospital for individuals under age 21 (as described in section 1905(h)) or of an institution for mental diseases providing medical assistance to individuals 65 years of age or older; and

"(II) whether or not the resident requires active treatment for mental illness.

"(ii) FOR MENTALLY RETARDED RESIDENTS.—As of April 1, 1990, in the case of each resident of a nursing facility who is mentally retarded, the State mental retardation or developmental disability authority must review and determine (using any criteria developed under subsection (f)(8))—

"(I) whether or not the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility or requires the level of services of an intermediate care facility described under section 1905(d); and

"(II) whether or not the resident requires active treatment for mental retardation.

"(iii) FREQUENCY OF REVIEWS.—

"(I) ANNUAL.—Except as provided in subclauses (II) and (III), the reviews and determinations under clauses (i) and (ii) must be conducted with respect to each mentally ill or mentally retarded resident not less often than annually.

"(II) PREADMISSION REVIEW CASES.—In the case of a resident subject to a preadmission review under subsection (b)(3)(F), the review and determination under clause (i) or (ii) need not be done until the resident has resided in the nursing facility for 1 year.

"(III) INITIAL REVIEW.—The reviews and determinations under clauses (i) and (ii) must first be conducted (for each resident not subject to preadmission review under subsection (b)(3)(F)) by not later than April 1, 1990.

"(C) RESPONSE TO PREADMISSION SCREENING AND RESIDENT REVIEW.—As of April 1, 1990, the State must meet the following requirements:

"(i) LONG-TERM RESIDENTS NOT REQUIRING NURSING FACILITY SERVICES, BUT REQUIRING ACTIVE TREATMENT.—In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility, but to require active treatment for mental illness or mental retardation, and who has continuously resided in a nursing facility for at least 30 months before the date of the determination, the State must, in consultation with the resident's family or legal representative and care-givers—

"(I) inform the resident of the institutional and noninstitutional alternatives covered under the State plan for the resident,

"(II) offer the resident the choice of remaining in the facility or of receiving covered services in an alternative appropriate institutional or noninstitutional setting,

"(III) clarify the effect on eligibility for services under the State plan if the resident chooses to leave the facility (including its effect on readmission to the facility), and

"(IV) regardless of the resident's choice, provide for (or arrange for the provision of) such active treatment for the mental illness or mental retardation.

A State shall not be denied payment under this title for nursing facility services for a resident described in this clause because the resident does not require the level of services provided by such a facility, if the resident chooses to remain in such a facility.

"(ii) OTHER RESIDENTS NOT REQUIRING NURSING FACILITY SERVICES, BUT REQUIRING ACTIVE TREATMENT.—In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility, but to require active treatment for mental illness or mental retardation, and who has not continuously resided in a nursing facility for at least 30 months before the date of the determination, the State must, in consultation with the resident's family or legal representative and care-givers—

"(I) arrange for the safe and orderly discharge of the resident from the facility, consistent with the requirements of subsection (c)(2),

"(II) prepare and orient the resident for such discharge, and

"(III) provide for (or arrange for the provision of) such active treatment for the mental illness or mental retardation.

"(iii) RESIDENTS NOT REQUIRING NURSING FACILITY SERVICES AND NOT REQUIRING ACTIVE TREATMENT.—In the case of a resident who is determined, under subparagraph (B), not to require the level of services provided by a nursing facility and not to require active treatment for mental illness or mental retardation, the State must—

"(I) arrange for the safe and orderly discharge of the resident from the facility, consistent with the requirements of subsection (c)(2), and

"(II) prepare and orient the resident for such discharge.

"(D) DENIAL OF PAYMENT WHERE FAILURE TO CONDUCT PREADMISSION SCREENING.—No payment may be made under section 1903(a) with respect to nursing facility services furnished to an individual for whom a determination

is required under subsection (b)(3)(F) or subparagraph (B) but for whom the determination is not made.

"(E) PERMITTING ALTERNATIVE DISPOSITION PLANS.—With respect to residents of a nursing facility who are mentally retarded or mentally ill and who are determined under subparagraph (B) not to require the level of services of such a facility, but who require active treatment for mental illness or mental retardation, a State and the nursing facility shall be considered to be in compliance with the requirement of this paragraph if, before October 1, 1988, the State and the Secretary have entered into an agreement relating to the disposition of such residents of the facility and the State is in compliance with such agreement. Such an agreement may provide for the disposition of the residents after the date specified in subparagraph (C).

"(F) APPEALS PROCEDURES.—Each State, as a condition of approval of its plan under this title, effective January 1, 1989, must have in effect an appeals process for individuals adversely affected by determinations under subparagraph (A) or (B).

"(G) DEFINITIONS.—In this paragraph and in subsection (b)(3)(F):

"(i) An individual is considered to be 'mentally ill' if the individual has a primary or secondary diagnosis of mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition) and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder).

"(ii) An individual is considered to be 'mentally retarded' if the individual is mentally retarded or a person with a related condition (as described in section 1905(d)).

"(iii) The term 'active treatment' has the meaning given such term by the Secretary in regulations, but does not include, in the case of a resident of a nursing facility, services within the scope of services which the facility must provide or arrange for its residents under subsection (b)(4).

"(f) RESPONSIBILITIES OF SECRETARY RELATING TO NURSING FACILITY REQUIREMENTS.—

"(1) GENERAL RESPONSIBILITY.—It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in nursing facilities under State plans approved under this title, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.

"(2) REQUIREMENTS FOR NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS AND FOR NURSE AIDE COMPETENCY EVALUATION PROGRAMS.—

"(A) IN GENERAL.—For purposes of subsections (b)(5) and (e)(1)(A), the Secretary shall establish, by not later than July 1, 1988—

"(i) requirements for the approval of nurse aide training and competency evaluation programs, including requirements relating to (I) the areas to be covered in such a program (including at least basic nursing skills, personal care skills, cognitive, behavioral and social care, basic restorative services, and residents' rights), content of the curriculum, (II) minimum hours of initial and ongoing training and retraining (including not less than 75 hours in the case of initial training), (III) qualifications of instructors, and (IV) procedures for determination of competency;

"(ii) requirements for the approval of nurse aide competency evaluation programs, including requirement relating to the areas to be covered in such a program, including at least basic nursing skills, personal care skills, cognitive, behavioral and social care, basic restorative services, and residents' rights, and procedures for determination of competency;

"(iii) requirements respecting the minimum frequency and methodology to be used by a State in reviewing such programs' compliance with the requirements for such programs.

"(B) APPROVAL OF CERTAIN PROGRAMS.—Such requirements—

"(i) may permit approval of programs offered by or in facilities, as well as outside facilities (including employee organizations), and of programs in effect on the date of the enactment of this section;

"(ii) shall permit a State to find that an individual who has completed (before January 1, 1989) a nurse aide training and competency evaluation program shall be deemed to have completed such a program approved under subsection (b)(5) if the State determines that, at the time the program was offered, the program met the requirements for approval under such paragraph; and

"(iii) shall prohibit approval of such a program—

"(I) offered by or in a nursing facility which has been determined to be out of compliance with the requirements of subsection (b), (c), or (d), within the previous 2 years, or

"(II) offered by or in a nursing facility unless the State makes the determination, upon an individual's completion of the program, that the individual is competent to provide nursing and nursing-related services in nursing facilities.

A State may not delegate its responsibility under clause (iii)(II) to the nursing facility.

"(3) FEDERAL GUIDELINES FOR STATE APPEALS PROCESS FOR TRANSFERS.—For purposes of subsections (c)(2)(B)(iii) and (e)(3), by not later than October 1, 1988, the Secretary shall establish guidelines for minimum standards which State appeals processes under subsection (e)(3) must meet to provide a fair mecha-

nism for hearing appeals on transfers of residents from nursing facilities.

"(4) SECRETARIAL STANDARDS QUALIFICATION OF ADMINISTRATORS.—For purposes of subsections (d)(1)(C) and (e)(4), the Secretary shall develop, by not later than March 1, 1988, standards to be applied in assuring the qualifications of administrators of nursing facilities.

"(5) CRITERIA FOR ADMINISTRATION.—The Secretary shall establish criteria for assessing a nursing facility's compliance with the requirement of subsection (d)(1) with respect to—

"(A) its governing body and management,

"(B) agreements with hospitals regarding transfers of residents to and from the hospitals and to and from other nursing facilities,

"(C) disaster preparedness,

"(D) direction of medical care by a physician,

"(E) laboratory and radiological services,

"(F) clinical records, and

"(G) resident and advocate participation.

"(6) SPECIFICATION OF RESIDENT ASSESSMENT DATA SET AND INSTRUMENTS.—The Secretary shall—

"(A) not later than January 1, 1989, specify a minimum data set of core elements and common definitions for use by nursing facilities in conducting the assessments required under subsection (b)(3), and establish guidelines for utilization of the data set; and

"(B) by not later than April 1, 1990, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subsection (e)(5)(A) for use by nursing facilities in complying with the requirements of subsection (b)(3)(A)(iii).

"(7) LIST OF ITEMS AND SERVICES FURNISHED IN NURSING FACILITIES NOT CHARGEABLE TO THE PERSONAL FUNDS OF A RESIDENT.—

"(A) REGULATIONS REQUIRED.—Pursuant to the requirement of section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, the Secretary shall issue regulations, on or before the first day of the seventh month to begin after the date of enactment of this section, that define those costs which may be charged to the personal funds of patients in nursing facilities who are individuals receiving medical assistance with respect to nursing facility services under this title and those costs which are to be included in the payment amount under this title for nursing facility services.

"(B) RULE IF FAILURE TO PUBLISH REGULATIONS.—If the Secretary does not issue the regulations under subparagraph (A) on or before the date required in that subparagraph, in the case of a resident of a nursing facility who is eligible to receive benefits for nursing facility services under this title, for purposes of section 1902(a)(28)(B), the Secretary shall be deemed to have promulgated regulations under this paragraph which provide that the costs which

may not be charged to the personal funds of such resident (and for which payment is considered to be made under this title) do not include, at a minimum, the costs for routine personal hygiene items and services furnished by the facility.

"(8) FEDERAL MINIMUM CRITERIA AND MONITORING FOR PREADMISSION SCREENING AND RESIDENT REVIEW.—

"(A) MINIMUM CRITERIA.—The Secretary shall develop, by not later than October 1, 1988, minimum criteria for States to use in making determinations under subsections (b)(3)(F) and (e)(7)(B) and in permitting individuals adversely affected to appeal such determinations, and shall notify the States of such criteria.

"(B) MONITORING COMPLIANCE.—The Secretary shall review a sufficient number of cases to allow reasonable inferences, each State's compliance with the requirements of subsection (e)(7)(C)(ii) (relating to discharge and placement for active treatment of certain residents).

"(8) CRITERIA FOR MONITORING STATE WAIVERS.—The Secretary shall develop, by not later than October 1, 1988, criteria and procedures for monitoring State performances in granting waivers pursuant to subsection (b)(4)(C)(ii).".

(b) INCORPORATING REQUIREMENTS INTO STATE PLAN.—

(1) IN GENERAL.—Section 1902(a) of such Act (42 U.S.C. 1396a(a)) is amended—

(A) in paragraph (13)(A), by inserting "which, in the case of nursing facilities, take into account the costs of complying with subsections (b) (other than paragraph (3)(F) thereof), (c), and (d) of section 1919 and provide (in the case of a nursing facility with a waiver under section 1919(b)(4)(C)(ii)) for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care," after "State" the second place it appears; and

(B) by amending paragraph (28) to read as follows:

"(28) provide—

"(A) that any nursing facility receiving payments under such plan must satisfy all the requirements of subsections (b) through (d) of section 1919 as they apply to such facilities;

"(B) for including in 'nursing facility services' at least the items and services specified (or deemed to be specified) by the Secretary under section 1919(f)(7) and making available upon request a description of the items and services so included;

"(C) for procedures to make available to the public the data and methodology used in establishing payment rates for nursing facilities under this title; and

"(D) for compliance (by the date specified in the respective sections) with the requirements of—

"(i) section 1919(f) (relating to implementation of nursing facility requirements, including paragraph (6)(B), relating to specification of resident assessment instrument);

"(ii) section 1919(g) (relating to responsibility for survey and certification of nursing facilities); and

"(iii) sections 1919(h)(2)(B) and 1919(h)(2)(D) (relating to establishment and application of remedies);".

(2) STATE PLAN AMENDMENT REQUIRED.—A plan of a State under title XIX of the Social Security Act shall not be considered to have met the requirement of section 1902(a)(13)(A) of the Social Security Act (as amended by paragraph (1)(A) of this subsection), as of the first day of a Federal fiscal year (beginning on or after October 1, 1990), unless the State has submitted to the Secretary of Health and Human Services, as of April 1 before the fiscal year, an amendment to such State plan to provide for an appropriate adjustment in payment amounts for nursing facility services furnished during the Federal fiscal year. The Secretary shall, not later than September 30 before the fiscal year concerned, review each such plan amendment for compliance with such requirement and by such date shall approve or disapprove each such amendment. If the Secretary disapproves such an amendment, the State shall immediately submit a revised amendment which meets such requirement. The absence of approval of such a plan amendment does not relieve the State or any nursing facility of any obligation or requirement under title XIX of the Social Security Act (as amended by this Act).

(c) EVALUATION.—The Secretary of Health and Human Services shall evaluate, and report to Congress by not later than January 1, 1993, on the implementation of the resident assessment process for residents of nursing facilities under the amendments made by this section.

(d) FUNDING.—

(1) IN GENERAL.—Section 1903(a)(2) of such Act (42 U.S.C. 1396b(a)(2)) is amended—

(A) by inserting "(A)" after "(2)", and

(B) by adding at the end the following new subparagraphs:

"(B) notwithstanding paragraph (1) or subparagraph (A), with respect to amounts expended for nursing aide training and competency evaluation programs, described in section 1919(e)(1), regardless of whether the programs are provided in or outside nursing facilities or of the skill of the personnel involved in such programs, an amount equal to 50 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to such programs; plus

"(C) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to preadmission screening and resident review activities conducted by the State under section 1919(e)(7); plus".

(2) ENHANCED FUNDING FOR NURSE AIDE TRAINING.—For calendar quarters during fiscal years 1988 and 1989, with respect to payment under section 1903(a)(2)(B) of the Social Security Act to a State for additional amounts expended by the State under

its plan approved under title XIX of such Act for nursing aide training and competency evaluation programs, and competency evaluation programs, described in section 1919(e)(1) of such title, any reference to "50 percent" is deemed a reference to the sum of the Federal medical assistance percentage (determined under section 1905(b) of such Act) plus 25 percentage points, but not to exceed 90 percent.

(e) REVISION OF PREVIOUS DEFINITIONS.—Section 1905 of such Act (42 U.S.C. 1396d) is amended—

(1) by amending subsection (c) to read as follows:

"(c) For definition of the term 'nursing facility', see section 1919(a).";

(2) in subsection (d)—

(A) by striking "intermediate care facility services" and inserting "intermediate care facility for the mentally retarded",

(B) by striking "may include services in a public" and inserting "means an",

(C) in paragraph (3), by inserting "in the case of a public institution," after "(3)";

(3) in subsection (f), by striking "skilled" each place it appears; and

(4) by striking subsection (i).

(f) MAKING COVERAGE OF NURSING FACILITY SERVICES MANDATORY FOR ADULTS.—Section 1905(a)(4)(A) of such Act (42 U.S.C. 1396d(a)(4)(A)) is amended by striking "skilled".

(g) ELIMINATION OF PAYMENT DIFFERENTIAL.—Section 1903 of such Act (42 U.S.C. 1396b) is amended—

(1) by striking subsection (h), and

(2) in subsection (a)(1), by striking ", (h), and" and inserting "and".

(h) CLARIFYING TERMINOLOGY.—(1) Section 1902(a)(10) of such Act (42 U.S.C. 1396a(a)(10)) is amended—

(A) in subparagraph (A)(ii)(VI), by striking "skilled" and by inserting "for the mentally retarded" after "intermediate care facility";

(B) in subparagraph (C)(iv), by striking "intermediate care facility services" and inserting "in an intermediate care facility"; and

(C) in subparagraph (D), by striking "skilled".

(2) Section 1902(a)(13) of such Act (42 U.S.C. 1396a(a)(13)) is amended—

(A) in subparagraph (A), by striking ", skilled nursing facility, and intermediate care facility services" and inserting "services, nursing facility services, and services in an intermediate care facility for the mentally retarded",

(B) in subparagraph (A), by striking ", skilled nursing facility, and intermediate care facility and" and inserting "nursing facility, and intermediate care facility for the mentally retarded and";

(C) in subparagraph (C), by striking "skilled nursing facilities and intermediate care facilities" and inserting "nursing facilities"; and

(D) in subparagraph (D)—

(i) by striking "skilled nursing facility or intermediate care facility" and inserting "nursing facility", and

(ii) by striking "skilled nursing facility services or intermediate care facility services" and inserting "nursing facility services".

(3) Section 1902(a)(30)(B) of such Act (42 U.S.C. 1396a(a)(30)(B)) is amended by striking "skilled nursing facility, intermediate care facility," each place it appears and inserting "intermediate care facility for the mentally retarded,".

(4) Section 1902(e)(3)(B)(i) of such Act (42 U.S.C. 1396a(e)(3)(B)(i)) is amended by striking "skilled nursing facility, or intermediate care facility" and inserting "nursing facility, or intermediate care facility for the mentally retarded".

(5) Section 1902(e)(9) of such Act (42 U.S.C. 1396a(e)(9)) is amended—

(A) in subparagraph (A)(iii), by striking "skilled nursing facility, or intermediate care facility," and inserting "nursing facility, or intermediate care facility for the mentally retarded", and

(B) in subparagraph (B), by striking "skilled nursing facilities, or intermediate care facilities" and inserting "nursing facilities, or intermediate care facilities for the mentally retarded".

(6) Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended—

(A) in paragraph (5), by striking "skilled",

(B) in paragraph (14), by striking ", skilled nursing facility services, and intermediate care facility services" and inserting "and nursing facility services", and

(C) in paragraph (15), by striking "intermediate care facility services (other than such services" and inserting "services in an intermediate care facility for the mentally retarded (other than".

(7) Section 1128B of such Act (42 U.S.C. 1320a-7b) is amended—

(A) in subsection (c), by striking "intermediate care facility" and inserting "nursing facility, intermediate care facility for the mentally retarded", and

(B) in subsection (d)(2)(A), by striking "skilled nursing facility, or intermediate care facility" and inserting "nursing facility, or intermediate care facility for the mentally retarded".

(8) Section 1911 of such Act (42 U.S.C. 1396j) is amended by striking ", intermediate care facility, or skilled nursing facility" each place it appears and inserting "or nursing facility".

(9) Section 1913 of such Act (42 U.S.C. 1396l) is amended—

(A) in the heading, by striking "SKILLED NURSING AND INTERMEDIATE CARE SERVICES" and inserting "NURSING FACILITY SERVICES";

(B) in subsection (a)—

(i) by striking "skilled nursing facility services and intermediate care facility services" and inserting "nursing facility services", and

(ii) by inserting before the period at the end the following: "and which, with respect to the provision of such services, meets the requirements of subsections (b) through (d) of section 1919";

(C) in subsection (b)(1)—

(i) by striking "skilled nursing or intermediate care facility services" and inserting "nursing facility services", and

(ii) by striking "skilled nursing and intermediate care facilities" and inserting "nursing facilities"; and

(D) in subsection (b)(3), by striking "skilled nursing or intermediate care facility services" and inserting "nursing facility services".

(10) Section 1915(c) of such Act (42 U.S.C. 1396n(c)) is amended—

(A) in paragraph (1), by striking "skilled nursing facility or intermediate care facility" and inserting "nursing facility or intermediate care facility for the mentally retarded";

(B) in paragraph (2)(B)(i), by striking ", skilled nursing facility, or intermediate care facility services" and inserting "services, nursing facility services, or services in an intermediate care facility for the mentally retarded";

(C) in paragraph (2)(B), by striking "need" and all that follows up to the semicolon and inserting "need for inpatient hospital services, nursing facility services, or services in an intermediate care facility for the mentally retarded";

(D) in paragraph (2)(C), by striking "or skilled nursing facility or intermediate care facility" and inserting ", nursing facility, or intermediate care facility for the mentally retarded";

(E) in paragraph (2)(C), by striking "or skilled nursing facility or intermediate care facility services" and inserting ", nursing facility services, or services in an intermediate care facility for the mentally retarded";

(F) in paragraph (5), by striking "skilled nursing facility or intermediate care facility" and inserting "nursing facility or intermediate care facility for the mentally retarded"; and

(G) in paragraph (7), by striking "or in skilled nursing or intermediate care facilities" and inserting ", nursing facilities, or intermediate care facilities for the mentally retarded".

(11) Section 1916 of such Act (42 U.S.C. 1396m) is amended, in subsections (a)(2)(C) and (b)(2)(C), by striking "skilled nursing facility, intermediate care facility" and inserting "nursing facility, intermediate care facility for the mentally retarded".

(12) Section 1917 of such Act (42 U.S.C. 1396p), as amended by this title, is further amended—

(A) in subsections (a)(1)(B)(i) and (c)(2)(B)(i), by striking "skilled nursing facility, intermediate care facility" and inserting "nursing facility, intermediate care facility for the mentally retarded", and

(B) in subsection (c)(3)(A), by striking "skilled".

(i) UTILIZATION REVIEW.—Section 1903(i)(4) of such Act (42 U.S.C. 1396b(i)(4)) is amended by striking "or skilled nursing facility" each place it appears.

(j) TECHNICAL ASSISTANCE.—The Secretary of Health and Human Services shall, upon request by a State, furnish technical assistance with respect to the development and implementation of reimbursement methods for nursing facilities that take into account the case mix of residents in the different facilities.

(k) REPORT ON STAFFING REQUIREMENTS.—The Secretary of Health and Human Services shall report to Congress, by not later

than January 1, 1993, on the progress made in implementing the nursing facility staffing requirements of subparagraph (C) of section 1919(b)(4) of the Social Security Act (as amended by subsection (a) of this section), including the number and types of waivers approved under subparagraph (C)(ii) of such section and the number of facilities which have received waivers.

(l) CONFORMING AMENDMENT.—Section 9516(c) of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking "section 1919" and inserting "section 1922".

SEC. 4212. SURVEY AND CERTIFICATION PROCESS.

(a) IN GENERAL.—Section 1919 of the Social Security Act, as inserted by section 4211, is amended by adding at the end the following new subsection:

"(g) SURVEY AND CERTIFICATION PROCESS.—

"(1) STATE AND FEDERAL RESPONSIBILITY.—

"(A) IN GENERAL.—Under each State plan under this title, the State shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of nursing facilities (other than facilities of the State) with the requirements of subsections (b), (c), and (d). The Secretary shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of State nursing facilities with the requirements of such subsections.

"(B) EDUCATIONAL PROGRAM.—Each State shall conduct periodic educational programs for the staff and residents (and their representatives) of nursing facilities in order to present current regulations, procedures, and policies under this section.

"(C) INVESTIGATION OF ALLEGATIONS OF RESIDENT NEGLECT AND ABUSE AND MISAPPROPRIATION OF RESIDENT PROPERTY.—The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection, for a process for the receipt, review, and investigation of allegations of resident neglect and abuse and misappropriation of resident property by a nurse aide in a nursing facility. If the State finds, after notice to the nurse aide involved and a reasonable opportunity for a hearing for the nurse aide to rebut allegations, that a nurse aide whose name is contained in a nurse aide registry has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding.

"(D) CONSTRUCTION.—The failure of the Secretary to establish standards under subsection (f) shall not relieve a State of its responsibility under this subsection.

"(2) SURVEYS.—

"(A) ANNUAL STANDARD SURVEY.—

"(i) IN GENERAL.—Each nursing facility shall be subject to an standard survey, to be conducted without any prior notice to the facility. Any individual who notifies (or causes to be notified) a nursing facility of the time or date on which such a survey is scheduled to be con-

ducted is subject to a civil money penalty of not to exceed $2,000. The Secretary shall provide for imposition of civil money penalties under this clause in a manner similar to that for the imposition of civil money penalties under section 1128A. The Secretary shall review each State's procedures for scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

"(ii) CONTENTS.—Each standard survey shall include, for a case-mix stratified sample of residents—

"(I) a survey of the quality of care furnished, as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutrition services, activities and social participation, and sanitation, infection control, and the physical environment,

"(II) written plans of care provided under subsection (b)(2) and an audit of the residents' assessments under subsection (b)(3) to determine the accuracy of such assessments and the adequacy of such plans of care, and

"(III) a review of compliance with residents' rights under subsection (c).

"(iii) FREQUENCY.—

"(I) IN GENERAL.—Each nursing facility shall be subject to a standard survey not later than 15 months after the date of the previous standard survey conducted under this subparagraph. The Statewide average interval between standard surveys of a nursing facility shall not exceed 12 months.

"(II) SPECIAL SURVEYS.—If not otherwise conducted under subclause (I), a standard survey (or an abbreviated standard survey) may be conducted within 2 months of any change of ownership, administration, management of a nursing facility, or director of nursing in order to determine whether the change has resulted in any decline in the quality of care furnished in the facility.

"(B) EXTENDED SURVEYS.—

"(i) IN GENERAL.—Each nursing facility which is found, under a standard survey, to have provided substandard quality of care shall be subject to an extended survey. Any other facility may, at the Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey).

"(ii) TIMING.—The extended survey shall be conducted immediately after the standard survey (or, if not practical, not later than 2 weeks after the date of completion of the standard survey).

"(iii) CONTENTS.—In such an extended survey, the survey team shall review and identify the policies and procedures which produced such substandard quality

of care and shall determine whether the facility has complied with all the requirements described in subsections (b), (c), and (d). Such review shall include an expansion of the size of the sample of residents' assessments reviewed and a review of the staffing, of in-service training, and, if appropriate, of contracts with consultants.

"(iv) CONSTRUCTION.—Nothing in this paragraph shall be construed as requiring an extended or partial extended survey as a prerequisite to imposing a sanction against a facility under subsection (h) on the basis of findings in a standard survey.

"(C) SURVEY PROTOCOL.—Standard and extended surveys shall be conducted—

"(i) based upon a protocol which the Secretary has developed, tested, and validated by not later than January 1, 1990, and

"(ii) by individuals, of a survey team, who meet such minimum qualifications as the Secretary establishes by not later than such date.

The failure of the Secretary to develop, test, or validate such protocols or to establish such minimum qualifications shall not relieve any State of its responsibility (or the Secretary of the Secretary's responsibility) to conduct surveys under this subsection.

"(D) CONSISTENCY OF SURVEYS.—Each State shall implement programs to measure and reduce inconsistency in the application of survey results among surveyors.

"(E) SURVEY TEAMS.—

"(i) IN GENERAL.—Surveys under this subsection shall be conducted by a multidisciplinary team of professionals (including a registered professional nurse).

"(ii) PROHIBITION OF CONFLICTS OF INTEREST.—A State may not use as a member of a survey team under this subsection an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the facility surveyed respecting compliance with the requirements of subsections (b), (c), and (d), or who has a personal or familial financial interest in the facility being surveyed.

"(iii) TRAINING.—The Secretary shall provide for the comprehensive training of State and Federal surveyors in the conduct of standard and extended surveys under this subsection, including the auditing of resident assessments and plans of care. No individual shall serve as a member of a survey team unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary.

"(3) VALIDATION SURVEYS.—

"(A) IN GENERAL.—The Secretary shall conduct onsite surveys of a representative sample of nursing facilities in each State, within 2 months of the date of surveys conducted under paragraph (2) by the State, in a sufficient number

to allow inferences about the adequacies of each State's surveys conducted under paragraph (2). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under paragraph (2). If the State has determined that an individual nursing facility meets the requirements of subsections (b), (c), and (d), but the Secretary determines that the facility does not meet such requirements, the Secretary's determination as to the facility's noncompliance with such requirements is binding and supersedes that of the State survey.

"(B) SCOPE.—With respect to each State, the Secretary shall conduct surveys under subparagraph (A) each year with respect to at least 5 percent of the number of nursing facilities surveyed by the State in the year, but in no case less than 5 nursing facilities in the State.

"(C) REDUCTION IN ADMINISTRATIVE COSTS FOR SUBSTANDARD PERFORMANCE.—If the Secretary finds, on the basis of such surveys, that a State has failed to perform surveys as required under paragraph (2) or that a State's survey and certification performance otherwise is not adequate, the Secretary may provide for the training of survey teams in the State and shall provide for a reduction of the payment otherwise made to the State under section 1903(a)(2)(D) with respect to a quarter equal to 33 percent multiplied by a fraction, the denominator of which is equal to the total number of residents in nursing facilities surveyed by the Secretary that quarter and the numerator of which is equal to the total number of residents in nursing facilities which were found pursuant to such surveys to be not in compliance with any of the requirements of subsections (b), (c), and (d). A State that is dissatisfied with the Secretary's findings under this subparagraph may obtain reconsideration and review of the findings under section 1116 in the same manner as a State may seek reconsideration and review under that section of the Secretary's determination under section 1116(a)(1).

"(C) SPECIAL SURVEYS OF COMPLIANCE.—Where the Secretary has reason to question the compliance of a nursing facility with any of the requirements of subsections (b), (c), and (d), the Secretary may conduct a survey of the facility and, on that basis, make independent and binding determinations concerning the extent to which the nursing facility meets such requirements.

"(4) INVESTIGATION OF COMPLAINTS AND MONITORING NURSING FACILITY COMPLIANCE.—Each State shall maintain procedures and adequate staff to—

"(A) investigate complaints of violations of requirements by nursing facilities, and

"(B) monitor, on-site, on a regular, as needed basis, a nursing facility's compliance with the requirements of subsections (b), (c), and (d), if—

"(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

"(ii) the facility was previously found not to be in compliance with such requirements, has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

"(iii) the State has reason to question the compliance of the facility with such requirements.

A State may maintain and utilize a specialized team (including an attorney, an auditor, and appropriate health care professionals) for the purpose of identifying, surveying, gathering and preserving evidence, and carrying out appropriate enforcement actions against chronically substandard nursing facilities.

"(5) DISCLOSURE OF RESULTS OF INSPECTIONS AND ACTIVITIES.—

"(A) PUBLIC INFORMATION.—Each State, and the Secretary, shall make available to the public—

"(i) information respecting all surveys and certifications made respecting nursing facilities, including statements of deficiencies and plans of correction,

"(ii) copies of cost reports of such facilities filed under this title or under title XVIII,

"(iii) copies of statements of ownership under section 1124, and

"(iv) information disclosed under section 1126.

"(B) NOTICE TO OMBUDSMAN.— Each State shall notify the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) of the State's findings of noncompliance with any of the requirements of subsections (b), (c), and (d), with respect to a nursing facility in the State.

"(C) NOTICE TO PHYSICIANS AND NURSING FACILITY ADMINISTRATOR LICENSING BOARD.—If a State finds that a nursing facility has provided substandard quality of care, the State shall notify—

"(i) the attending physician of each resident with respect to which such finding is made, and

"(ii) any State board responsible for the licensing of the nursing facility administrator of the facility.

"(D) ACCESS TO FRAUD CONTROL UNITS.—Each State shall provide its State medicaid fraud and abuse control unit (established under section 1903(q)) with access to all information of the State agency responsible for surveys and certifications under this subsection.".

(b) POSTING SURVEY RESULTS.—Section 1864(a) of such Act (42 U.S.C. 1395aa(a)) is amended by inserting, after "readily available form and place" in the fifth sentence, the following: ", and require (in the case of skilled nursing facilities) the posting in a place readily accessible to patients (and patients' representatives),".

(c) INCREASING MATCHING PERCENTAGE FOR NURSING HOME SURVEY AND CERTIFICATION ACTIVITIES.—(1) Section 1903(a)(2) of such Act (42 U.S.C. 1396b(a)(2)), as amended by this title, is further amended by adding at the end the following new subparagraph:

"(D) for each calendar quarter during—

"(i) fiscal year 1991, an amount equal to 90 percent,

"(ii) fiscal year 1992, an amount equal to 85 percent,

"(iii) fiscal year 1993, an amount equal to 80 percent, and

"(iv) fiscal year 1994 and thereafter, an amount equal to 75 percent,

of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to State activities under section 1919(g); plus".

(2) Section 1903(r) of such Act (42 U.S.C. 1396b(r)) is amended by striking "paragraphs (2)" each place it appears and inserting "paragraphs (2)(A)".

(3) For purposes of section 1903(a) of the Social Security Act, proper expenses incurred by a State for medical review by independent professionals of the care provided to residents of nursing facilities who are entitled to medical assistance under title XIX of such Act shall be reimbursable as expenses necessary for the proper and efficient administration of the State plan under that title.

(d) REVISION OF PENALTY PROVISIONS.—(1) Section 1903(g) of such Act (42 U.S.C. 1396b(g)) is amended—

(A) in paragraph (1)—

(i) by striking "or intermediate care facility services" the first place it appears and inserting "or services in an intermediate care facility for the mentally retarded",

(ii) by striking ", skilled nursing facility services for 30 days,",

(iii) by striking ", skilled nursing facility services, or intermediate care facility services" and inserting "or services in an intermediate care facility for the mentally retarded",

(iv) by striking ", skilled nursing facilities, and intermediate care facilities" and inserting "and intermediate care facilities for the mentally retarded";

(B) in paragraph (4)(B), by striking ", skilled nursing facilities, and intermediate care facilities" and inserting "and intermediate care facilities for the mentally retarded";

(C) in paragraph (6)—

(i) by striking subparagraph (B),

(ii) in subparagraph (C), by striking "intermediate care facility services" and inserting "services in an intermediate care facility for the mentally retarded", and

(iii) by redesignating subparagraphs (C) and (D) as subparagraphs (B) and (C), respectively; and

(D) by striking paragraph (7).

(2) Section 1902(a)(31) of such Act (42 U.S.C. 1396a(a)(31)) is amended—

(A) in the matter before subparagraph (A), by striking "skilled nursing facility services" and all that follows through "where" and inserting "services in an intermediate care facility for the mentally retarded (where", and

(B) in subparagraph (B), by striking "skilled nursing or intermediate care facility" and inserting "intermediate care facility for the mentally retarded".

(3) Section 1902(a)(33)(B) of such Act (42 U.S.C. 1396a(a)(33)(B)) is amended by inserting ", except as provided in section 1919(d)," after "(B) that".

(4) The amendments made by this subsection shall not apply to a State until such date (not earlier than October 1, 1990) as of which the Secretary determines that—

(A) the State has specified the resident assessment instrument under section 1919(e)(5) of the Social Security Act, and

(B) the State has begun conducting surveys under section 1919(g)(2) of such Act.

(e) MISCELLANEOUS CONFORMING AMENDMENTS.—(1) Section 1902(a)(44) of such Act (42 U.S.C. 1396a(a)(44)) is amended—

(A) in the matter before subparagraph (A), by striking "skilled nursing facility services, intermediate care facility services" and inserting "services in an intermediate care facility for the mentally retarded", and

(B) in subparagraph (A), by striking "that are intermediate care facility services in an institution for the mentally retarded" and inserting "that are services in an intermediate care facility for the mentally retarded".

(2) Section 1903(a)(7) of such Act (42 U.S.C. 1396b(a)(7)) is amended by inserting "subject to section 1919(g)(3)(B)," after "(7)".

(3) Section 1910 of such Act (42 U.S.C. 1396i) is amended—

(A) by striking "SKILLED NURSING FACILITIES AND" in the heading,

(B) by striking subsection (a), and

(C) by redesignating subsections (b) and (c) as subsections (a) and (b), respectively.

(4) Section 1866(c) of such Act (42 U.S.C. 1395cc(c)) is amended by striking paragraph (2) and by redesignating paragraph (3) as paragraph (2).

SEC. 4213. ENFORCEMENT PROCESS.

(a) IN GENERAL.—Section 1919 of the Social Security Act, as inserted by section 4201 and amended by section 4202, is further amended by adding at the end the following new subsection:

"(h) ENFORCEMENT PROCESS.—

"(1) IN GENERAL.—If a State finds, on the basis of a standard, extended, or partial extended survey under subsection (g)(2) or otherwise, that a nursing facility no longer meets a requirement of subsection (b), (c), or (d), and further finds that the facility's deficiencies—

"(A) immediately jeopardize the health or safety of its residents, the State shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(A)(iii), or terminate the facility's participation under the State plan and may provide, in addition, for one or more of the other remedies described in paragraph (2); or

"(B) do not immediately jeopardize the health or safety of its residents, the State may—

"(i) terminate the facility's participation under the State plan,

"(ii) provide for one or more of the remedies described in paragraph (2), or

"(iii) do both.

Nothing in this paragraph shall be construed as restricting the remedies available to a State to remedy a nursing facility's deficiencies. If a State finds that a nursing facility meets the requirements of subsections (b), (c), and (d), but, as of a previous period, did not meet such requirements, the State may provide for a civil money penalty under paragraph (2)(A)(i) for the days in which it finds that the facility was not in compliance with such requirements.

"(2) SPECIFIED REMEDIES.—

"(A) LISTING.—Except as provided in subparagraph (B)(ii), each State shall establish by law (whether statute or regulation) at least the following remedies:

"(i) Denial of payment under the State plan with respect to any individual admitted to the nursing facility involved after such notice to the public and to the facility as may be provided for by the State.

"(ii) A civil money penalty assessed and collected, with interest, for each day in which the facility is or was out of compliance with a requirement of subsection (b), (c), or (d). Funds collected by a State as a result of imposition of such a penalty (or as a result of the imposition by the State of a civil money penalty for activities described in subsections (b)(3)(B)(ii)(I), (b)(3)(B)(ii)(II), or (g)(2)(A)(i)) shall be applied to the protection of the health or property of residents of nursing facilities that the State or the Secretary finds deficient, including payment for the costs of relocation of residents to other facilities, maintenance of operation of a facility pending correction of deficiencies or closure, and reimbursement of residents for personal funds lost.

"(iii) The appointment of temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

"(I) there is an orderly closure of the facility, or

"(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d).

The temporary management under this clause shall not be terminated under subclause (II) until the State has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d).

"(iv) The authority, in the case of an emergency, to close the facility, to transfer residents in that facility to other facilities, or both.

The State also shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In ad-

dition, the State may provide for other specified remedies, such as directed plans of correction.

"(B) DEADLINE AND GUIDANCE.—(i) Except as provided in clause (ii), as a condition for approval of a State plan for calendar quarters beginning on or after October 1, 1989, each State shall establish the remedies described in clauses (i) through (iv) of subparagraph (A) by not later than October 1, 1989. The Secretary shall provide, through regulations or otherwise by not later than October 1, 1988, guidance to States in establishing such remedies; but the failure of the Secretary to provide such guidance shall not relieve a State of the responsibility for establishing such remedies.

"(ii) A State may establish alternative remedies (other than termination of participation) other than those described in clauses (i) through (iv) of subparagraph (A), if the State demonstrates to the Secretary's satisfaction that the alternative remedies are as effective in deterring noncompliance and correcting deficiencies as those described in subparagraph (A).

"(C) ASSURING PROMPT COMPLIANCE.—If a nursing facility has not complied with any of the requirements of subsections (b), (c), and (d), within 3 months after the date the facility is found to be out of compliance with such requirements, the State shall impose the remedy described in subparagraph (A)(i) for all individuals who are admitted to the facility after such date.

"(D) REPEATED NONCOMPLIANCE.—In the case of a nursing facility which, on 3 consecutive standard surveys conducted under subsection (g)(2), has been found to have provided substandard quality of care, the State shall (regardless of what other remedies are provided)—

"(i) impose the remedy described in subparagraph (A)(i), and

"(ii) monitor the facility under subsection (g)(4)(B),

until the facility has demonstrated, to the satisfaction of the State, that it is in compliance with the requirements of subsections (b), (c), and (d), and that it will remain in compliance with such requirements.

"(E) FUNDING.—The reasonable expenditures of a State to provide for temporary management and other expenses associated with implementing the remedies described in clauses (iii) and (iv) of subparagraph (A) shall be considered, for purposes of section 1903(a)(7), to be necessary for the proper and efficient administration of the State plan.

"(F) INCENTIVES FOR HIGH QUALITY CARE.—In addition to the remedies specified in this paragraph, a State may establish a program to reward, through public recognition, incentive payments, or both, nursing facilities that provide the highest quality care to residents who are entitled to medical assistance under this title. For purposes of section 1903(a)(7), proper expenses incurred by a State in carrying out such a program shall be considered to be expenses necessary for the proper and efficient administration of the State plan under this title.

"(3) SECRETARIAL AUTHORITY.—

"(A) FOR STATE NURSING FACILITIES.—With respect to a State nursing facility, the Secretary shall have the authority and duties of a State under this subsection, including the authority to impose remedies described in clauses (i), (ii), and (iii) of paragraph (2)(A).

"(B) OTHER NURSING FACILITIES.—With respect to any other nursing facility in a State, if the Secretary finds that a nursing facility no longer meets a requirement of subsection (b), (c), (d), or (e), and further finds that the facility's deficiencies—

"(i) immediately jeopardize the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subparagraph (C)(iii), or terminate the facility's participation under the State plan and may provide, in addition, for one or more of the other remedies described in subparagraph (C); or

"(ii) do not immediately jeopardize the health or safety of its residents, the Secretary may impose any of the remedies described in subparagraph (C).

Nothing in this subparagraph shall be construed as restricting the remedies available to the Secretary to remedy a nursing facility's deficiencies. If the Secretary finds that a nursing facility meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (C)(ii) for the days on which he finds that the facility was not in compliance with such requirements.

"(C) SPECIFIED REMEDIES.—The Secretary may take the following actions with respect to a finding that a facility has not met an applicable requirement:

"(i) DENIAL OF PAYMENT.—The Secretary may deny any further payments to the State for medical assistance furnished by the facility to all individuals in the facility or to individuals admitted to the facility after the effective date of the finding.

"(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—The Secretary may impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance and the Secretary shall impose and collect such a penalty in the same manner as civil money penalties are imposed and collected under section 1128A.

"(iii) APPOINTMENT OF TEMPORARY MANAGEMENT.—In consultation with the State, the Secretary may appoint temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

"(I) there is an orderly closure of the facility, or

"(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d).

The temporary management under this clause shall not be terminated under subclause (II) until the Secretary has determined that the facility has the management capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d).

The Secretary shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the Secretary may provide for other specified remedies, such as directed plans of correction.

"(D) CONTINUATION OF PAYMENTS PENDING REMEDIATION.—The Secretary may continue payments, over a period of not longer than 6 months, under this title with respect to a nursing facility not in compliance with a requirement of subsection (b), (c), or (d), if—

"(i) the State survey agency finds that it is more appropriate to take alternative action to assure compliance of the facility with the requirements than to terminate the certification of the facility,

"(ii) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

"(iii) the State agrees to repay to the Federal Government payments received under this subparagraph if the corrective action is not taken in accordance with the approved plan and timetable.

The Secretary shall establish guidelines for approval of corrective actions requested by States under this subparagraph.

"(4) EFFECTIVE PERIOD OF DENIAL OF PAYMENT.—A finding to deny payment under this subsection shall terminate when the State or Secretary (or both, as the case may be) finds that the facility is in substantial compliance with all the requirements of subsections (b), (c), and (d).

"(5) IMMEDIATE TERMINATION OF PARTICIPATION FOR FACILITY WHERE STATE OR SECRETARY FINDS NONCOMPLIANCE AND IMMEDIATE JEOPARDY.—If either the State or the Secretary finds that a nursing facility has not met a requirement of subsection (b), (c), or (d), and finds that the failure immediately jeopardizes the health or safety of its residents, the State and the Secretary shall notify the other of such finding, and the State or the Secretary, respectively, shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(A)(iii) or (3)(C)(iii), or terminate the facility's participation under the State plan. If the facility's participation in the State plan is terminated by either the State or the Secretary, the State shall provide for the safe and orderly transfer of the residents eligible under the State plan consistent with the requirements of subsection (c)(2).

"(6) SPECIAL RULES WHERE STATE AND SECRETARY DO NOT AGREE ON FINDING OF NONCOMPLIANCE.—

"(A) STATE FINDING OF NONCOMPLIANCE AND NO SECRETARIAL FINDING OF NONCOMPLIANCE.—If the Secretary finds that a nursing facility has met all the requirements of subsections (b), (c), and (d), but a State finds that the facility has not met such requirements and the failure does not immediately jeopardize the health or safety of its residents, the State's findings shall control and the remedies imposed by the State shall be applied.

"(B) SECRETARIAL FINDING OF NONCOMPLIANCE AND NO STATE FINDING OF NONCOMPLIANCE.—If the Secretary finds that a nursing facility has not met all the requirements of subsections (b), (c), and (d), and that the failure does not immediately jeopardize the health or safety of its residents, but the State has not made such a finding, the Secretary—

"(i) may impose any remedies specified in paragraph (3)(C) with respect to the facility, and

"(ii) shall (pending any termination by the Secretary) permit continuation of payments in accordance with paragraph (3)(D).

"(7) SPECIAL RULES FOR TIMING OF TERMINATION OF PARTICIPATION WHERE REMEDIES OVERLAP.—If both the Secretary and the State find that a nursing facility has not met all the requirements of subsections (b), (c), and (d), and neither finds that the failure immediately jeopardizes the health or safety of its residents—

"(A)(i) if both find that the facility's participation under the State plan should be terminated, the State's timing of any termination shall control so long as the termination date does not occur later than 6 months after the date of the finding to terminate;

"(ii) if the Secretary, but not the State, finds that the facility's participation under the State plan should be terminated, the Secretary shall (pending any termination by the Secretary) permit continuation of payments in accordance with paragraph (3)(D); or

"(iii) if the State, but not the Secretary, finds that the facility's participation under the State plan should be terminated, the State's decision to terminate, and timing of such termination, shall control; and

"(B)(i) if the Secretary or the State, but not both, establishes one or more remedies which are additional or alternative to the remedy of terminating the facility's participation under the State plan, such additional or alternative remedies shall also be applied, or

"(ii) if both the Secretary and the State establish one or more remedies which are additional or alternative to the remedy of terminating the facility's participation under the State plan, only the additional or alternative remedies of the Secretary shall apply.

"(8) CONSTRUCTION.—The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such

other remedies, including any remedy available to an individual at common law. The remedies described in clauses (i), (iii), and (iv) of paragraph (2)(A) may be imposed during the pendency of any hearing.

"(9) SHARING OF INFORMATION.—Notwithstanding any other provision of law, all information concerning nursing facilities required by this section to be filed with the Secretary or a State agency shall be made available to Federal or State employees for purposes consistent with the effective administration of programs established under this title and title XVIII, including investigations by State medicaid fraud control units.".

(b) CONFORMING AMENDMENTS.—(1) Section 1902 of such Act (42 U.S.C. 1396a) is amended by striking subsection (i).

(2) Section 1903(i) of such Act (42 U.S.C. 1396b(i)) is amended by striking the period at the end of paragraph (7) and inserting "; or" and by adding at the end the following new paragraph:

"(8) with respect to any amount expended for medical assistance for nursing facility services to reimburse (or otherwise compensate) a nursing facility for payment of a civil money penalty imposed under section 1919(h).".

SEC. 4214. EFFECTIVE DATES.

(a) NEW REQUIREMENTS AND SURVEY AND CERTIFICATION PROCESS.—Except as otherwise specifically provided in section 1919 of the Social Security Act, the amendments made by sections 4211 and 4212 (relating to nursing facility requirements and survey and certification requirements) shall apply to nursing facility services furnished on or after October 1, 1990, without regard to whether regulations to implement such amendments are promulgated by such date; except that section 1902(a)(28)(B) of the Social Security Act (as amended by section 4211(b) of this Act), relating to requiring State medical assistance plans to specify the services included in nursing facility services, shall apply to calendar quarters beginning more than 6 months after the date of the enactment of this Act, without regard to whether regulations to implement such section are promulgated by such date.

(b) ENFORCEMENT.—(1) Except as otherwise specifically provided in section 1919 of the Social Security Act, the amendments made by section 4213 of this Act apply to payments under title XIX of the Social Security Act for calendar quarters beginning on or after the date of the enactment of this Act, without regard to whether regulations to implement such amendments are promulgated by such date.

(c) TRANSITIONAL RULE.—In applying the amendments made by this part for services furnished before October 1, 1990—

(A) any reference to a nursing facility is deemed a reference to a skilled nursing facility or intermediate care facility (other than an intermediate care facility for the mentally retarded), and

(B) with respect to such a skilled nursing facility or intermediate care facility, any reference to a requirement of subsection (b), (c), or (d), is deemed a reference to the provisions of section 1861(j) or section 1905(c), respectively, of the Social Security Act.

(d) WAIVER OF PAPERWORK REDUCTION.—Chapter 35 of title 44, United States Code, shall not apply to information required for pur-

poses of carrying out this part and implementing the amendments made by this part.

SEC. 4215. ANNUAL REPORT.

The Secretary of Health and Human Services shall report to the Congress annually on the extent to which nursing facilities are complying with the requirements of subsections (b), (c), and (d) of section 1919 of the Social Security Act (as added by the amendments made by this part) and the number and type of enforcement actions taken by States and the Secretary under section 1919(h) of such Act (as added by section 4213 of this Act).

SEC. 4216. CONSTRUCTION.

Section 1919 of the Social Security Act is amended by adding at the end the following new subsection:

"(i) CONSTRUCTION.—Where requirements or obligations under this section are identical to those provided under section 1819 of this Act, the fulfillment of those requirements or obligations under section 1819 shall be considered to be the fulfillment of the corresponding requirements or obligations under this section.".

SEC. 4217. FINAL REGULATIONS WITH RESPECT TO PLANS OF CORRECTION OR REDUCTION.

(a) IN GENERAL.—Not later than 30 days after the date of enactment of this Act, the Secretary of Health and Human Services shall promulgate final regulations to implement the amendments made by section 9516 of the Consolidated Omnibus Budget Reconciliation Act of 1985.

(b) The regulations promulgated under paragraph (1) shall be effective as if promulgated on the date of enactment of the Consolidated Omnibus Budget Reconciliation Act of 1985.

SEC. 4218. MEDICAID CERTIFICATIONS AND RECERTIFICATIONS FOR CERTAIN SERVICES.

(a) IN GENERAL.—Section 1902(a)(44) of the Social Security Act (42 U.S.C. 1396a(a)(44)) is amended—

(1) in subparagraph (A)—

(A) by striking "physician certifies" and inserting "physician (or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician) certifies", and

(B) by striking "the physician, or a physician assistant or nurse practitioner under the supervision of a physician," and inserting "a physician, a physician assistant under the supervision of a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician,"; and

(2) in subparagraph (B), by striking "a physician;" and inserting "a physician, or, in the case of skilled nursing facility services or intermediate care facility services, a physician, or a nurse practitioner or clinical nurse specialist who is not an em-

ployee of the facility but is working in collaboration with a physician;".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to certifications or recertifications during the period beginning on July 1, 1988, and ending on October 1, 1990.

Subtitle D—Vaccine Compensation

SEC. 4301. SHORT TITLE, REFERENCE.

(a) SHORT TITLE.—This subtitle may be cited as the "Vaccine Compensation Amendments of 1987".

(b) REFERENCE.—Whenever in this subtitle (other than in section 4302(a)) an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Public Health Service Act.

SEC. 4302. EFFECTIVE DATE.

(a) IN GENERAL.—Section 323(a) of the National Childhood Vaccine Injury Act of 1986 (42 U.S.C. 300aa-1 note) is amended by striking out "Subtitle 2 of such title and this title shall take effect on the effective date of a tax" and all that follows in that section and inserting in lieu thereof "parts A and B of subtitle 2 of such title shall take effect on October 1, 1988 and parts C and D of such title and this title shall take effect on the date of the enactment of the Vaccine Compensation Amendments of 1987.".

(b) REFERENCES.—

(1) Sections 2111, 2115, 2119(a), 2122, 2123, 2125, 2126, 2127, and 2128 (42 U.S.C. 300aa-11, 300aa-15, 300aa-199a), 300aa-22, 300aa-23, 300aa-25, 300aa-26, 300aa-27, 300aa-28) are each amended by striking out "effective date of this subtitle" each place it appears and inserting in lieu thereof "effective date of this part".

(2) Sections 2111(a)(5)(A), 2115(e)(2) and 2116 (42 U.S.C. 300aa-11(a)(5)(A), 300aa-15(e)(2), 300a-16) are each amended by striking out "effective date of this title" each place it appears and inserting in lieu thereof "effective date of this part".

SEC. 4303. COMPENSATION.

(a) SOURCE.—Section 2115 (42 U.S.C. 300aa-15) is amended by adding at the end the following:

"(i) SOURCE OF COMPENSATION.—

"(1) Payment of compensation under the Program to a petitioner for a vaccine-related injury or death associated with the administration of a vaccine before the effective date of this part shall be made from appropriations under subsection (i).

"(2) Payment of compensation under the Program to a petitioner for a vaccine-related injury or death associated with the administration of a vaccine on or after the effective date of this part shall be made from the Vaccine Injury Compensation Trust Fund established under section 9510 of the Internal Revenue Code of 1986.".

(4) Section 2113(c) (42 U.S.C. 300aa-13(c)) is amended by striking out "a district court of the United States" and inserting in lieu thereof "the United States Claims Court".

(5) Section 2115(e)(1) (42 U.S.C. 300aa-15(e)(1)) is amended by striking out "of a court" and inserting in lieu thereof "of the United States Claims Court".

(6) Paragraph (2) of subsection (f) of section 2115 (42 U.S.C. 300aa-15) is amended by striking out "district court of the United States" and inserting in lieu thereof "United States Claims Court".

(7) Section 2117(a) (42 U.S.C. 300aa-17(a)) is amended by striking out "(1)", by running in the text of paragraph (1) into the subsection heading, and by striking out paragraph (2).

(8) Section 2121(a) (42 U.S.C. 300aa-21(a)) is amended by striking out "a district court of the United States" and inserting in lieu thereof "the United States Claims Court" and by striking out "a court" each place it occurs and inserting in lieu thereof "the court".

(9) Section 2123(e) (42 U.S.C. 300aa-23(e)) is amended by striking out "a district court of the United States" and inserting in lieu thereof "the United States Claims Court".

Subtitle E—Rural Health

SEC. 4401. OFFICE OF RURAL HEALTH POLICY.

Title VII of the Social Security Act is amended by adding at the end thereof the following new section:

"OFFICE OF RURAL HEALTH POLICY

"SEC. 711. (a) There shall be established in the Department of Health and Human Services (in this section referred to as the "Department") an Office of Rural Health Policy (in this section referred to as the 'Office'). The Office shall be headed by a Director, who shall advise the Secretary on the effects of current policies and proposed statutory, regulatory, administrative, and budgetary changes in the programs established under titles XVIII and XIX on the financial viability of small rural hospitals, the ability of rural areas (and rural hospitals in particular) to attract and retain physicians and other health professionals, and access to (and the quality of) health care in rural areas.

"(b) In addition to advising the Secretary with respect to the matters specified in subsection (a), the Director, through the Office, shall—

"(1) oversee compliance with the requirements of section 1102(b) of this Act and section 4083 of the Omnibus Budget Reconciliation Act of 1987,

"(2) establish and maintain a clearinghouse for collecting and disseminating information on—

"(A) rural health care issues,

"(B) research findings relating to rural health care, and

"(C) innovative approaches to the delivery of health care in rural areas,

"(3) coordinate the activities within the Department that relate to rural health care, and

"(4) provide information to the Secretary and others in the Department with respect to the activities, of other Federal departments and agencies, that relate to rural health care.".

SEC. 4402. IMPACT ANALYSES OF MEDICARE AND MEDICAID RULES AND REGULATIONS ON SMALL RURAL HOSPITALS.

(a) IN GENERAL.—Section 1102 of the Social Security Act (42 U.S.C. 1302) is amended—

(1) by inserting "(a)" after "SEC. 1102.", and

(2) by adding at the end thereof the following new subsection:

"(b)(1) Whenever the Secretary publishes a general notice of proposed rulemaking for any rule or regulation proposed under title XVIII, title XIX, or part B of this title that may have a significant impact on the operations of a substantial number of small rural hospitals, the Secretary shall prepare and make available for public comment an initial regulatory impact analysis. Such analysis shall describe the impact of the proposed rule or regulation on such hospitals and shall set forth, with respect to small rural hospitals, the matters required under section 603 of title 5, United States Code, to be set forth with respect to small entities. The initial regulatory impact analysis (or a summary) shall be published in the Federal Register at the time of the publication of general notice of proposed rulemaking for the rule or regulation.

"(2) Whenever the Secretary promulgates a final version of a rule or regulation with respect to which an initial regulatory impact analysis is required by paragraph (1), the Secretary shall prepare a final regulatory impact analysis with respect to the final version of such rule or regulation. Such analysis shall set forth, with respect to small rural hospitals, the matters required under section 604 of title 5, United States Code, to be set forth with respect to small entities. The Secretary shall make copies of the final regulatory impact analysis available to the public and shall publish, in the Federal Register at the time of publication of the final version of the rule or regulation, a statement describing how a member of the public may obtain a copy of such analysis.

"(3) If a regulatory flexibility analysis is required by chapter 6 of title 5, United States Code, for a rule or regulation to which this subsection applies, such analysis shall specifically address the impact of the rule or regulation on small rural hospitals.".

(b) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to regulations proposed more than 30 days after the date of the enactment of this Act.

SEC. 4403. SET ASIDE FOR EXPERIMENTS AND DEMONSTRATION PROJECTS RELATING TO RURAL HEALTH CARE ISSUES.

(a) SET ASIDE.—Not less than ten percent of the total amounts expended in each fiscal year by the Secretary of Health and Human Services (in this section referred to as the "Secretary") after October 1, 1988, with respect to experiments and demonstration projects authorized by section 402 of the Social Security Amendments of 1967 and the experiments and demonstration projects authorized by the Social Security Amendments of 1972 shall be expended for experiments and demonstration projects relating exclusively or substan-

tially to rural health issues, including (but not limited to) the impact of the payment methodology under section 1886(d) of the Social Security Act on the financial viability of small rural hospitals, the effect of medicare payment policies on the ability of rural areas (and rural hospitals in particular) to attract and retain physicians and other health professionals, the appropriateness of medicare conditions of participation and staffing requirements for small rural hospitals, and the impact of medicare policies on access to (and the quality of) health care in rural areas.

(b) AGENDA.—The Secretary of Health and Human Services shall establish an agenda of experiments and demonstration projects, relating exclusively or substantially to rural health issues, that are in progress or have been proposed, and shall include such agenda in the annual report submitted pursuant to section 1875(b) of the Social Security Act. The agenda shall be accompanied by a statement setting forth the amounts that have been obligated and expended with respect to such experiments and projects in the current and most recently completed fiscal years.

TITLE V—ENERGY AND ENVIRONMENT PROGRAMS

Subtitle A—Nuclear Waste Amendments

SEC. 5001. SHORT TITLE.

This subtitle may be cited as the "Nuclear Waste Policy Amendments Act of 1987".

SEC. 5002. DEFINITIONS.

Section 2 of the Nuclear Waste Policy Act of 1982 (42 U.S.C. 10101) is amended by adding at the end the following new paragraphs:

"(30) The term 'Yucca Mountain site' means the candidate site in the State of Nevada recommended by the Secretary to the President under section 112(b)(1)(B) on May 27, 1986.

"(31) The term 'affected unit of local government' means the unit of local government with jurisdiction over the site of a repository or a monitored retrievable storage facility. Such term may, at the discretion of the Secretary, include units of local government that are contiguous with such unit.

"(32) The term 'Negotiator' means the Nuclear Waste Negotiator.

"(33) As used in title IV, the term 'Office' means the Office of the Nuclear Waste Negotiator established under title IV of this Act.

"(34) The term 'monitored retrievable storage facility' means the storage facility described in section 141(b)(1).".

TITLE IX—INCOME SECURITY AND RELATED PROGRAMS

TABLE OF CONTENTS

Subtitle A—OASDI Provisions

PART 1—COVERAGE AND BENEFITS

Sec. 9001. Coverage of inactive duty military training.
Sec. 9002. Coverage of all cash pay of agricultural employees whose employers spend $2,500 or more a year for agricultural labor.
Sec. 9003. Coverage of the employer cost of group-term life insurance.
Sec. 9004. Coverage of services performed by one spouse in the employ of the other.
Sec. 9005. Treatment of service performed by an individual in the employ of a parent.
Sec. 9006. Application of employer taxes to employees' cash tips.
Sec. 9007. Applicability of Government pension offset to certain Federal employees.
Sec. 9008. Modification of agreement with Iowa to provide coverage for certain policemen and firemen.
Sec. 9009. Continuation of disability benefits during appeal.
Sec. 9010. Extension of disability re-entitlement period from 15 months to 36 months.

PART 2—OTHER SOCIAL SECURITY PROVISIONS

Sec. 9021. Moratorium on reductions in attorneys' fees; studies of attorneys' fee payment system.
Sec. 9022. Corporate directors.
Sec. 9023. Technical corrections.

PART 3—RAILROAD RETIREMENT PROGRAM

Sec. 9031. Increase in rates of tier 2 Railroad Retirement Tax on employees for 1988 and thereafter.
Sec. 9032. Increase in rates of tier 2 Railroad Retirement Tax on employers for 1988 and thereafter.
Sec. 9033. Commission on Railroad Retirement Reform.
Sec. 9034. Transfer to railroad retirement account.

Subtitle B—Provisions Relating to Public Assistance and Unemployment Compensation

PART 1—AFDC AND SSI AMENDMENTS

Sec. 9101. Permanent extension of disregard of nonprofit organizations' in-kind assistance to SSI and AFDC recipients.
Sec. 9102. Fraud control under AFDC program.
Sec. 9103. Exclusion of real property when it cannot be sold.
Sec. 9104. Adjustment of penalty where asset is transferred for less than fair market value.
Sec. 9105. Exclusion of interest on burial accounts.
Sec. 9106. Exception from SSI retrospective accounting for AFDC and certain other assistance payments.
Sec. 9107. Technical amendment relating to 1986 amendment concerning the treatment of certain couples in medical institutions.
Sec. 9108. Extension of deadline for disabled widows to apply for Medicaid protection under 1984 amendments.
Sec. 9109. Increase in SSI emergency advance payments.
Sec. 9110. Modification of interim assistance reimbursement program.
Sec. 9111. Special notice to blind recipients.
Sec. 9112. Rehabilitation services for blind SSI recipients.
Sec. 9113. Extending the number of months that an individual in a public emergency shelter can be eligible for SSI.
Sec. 9114. Exclusion of underpayments from resources.
Sec. 9115. Continuation of full benefit standard for individuals temporarily institutionalized.
Sec. 9116. Retention of Medicaid when SSI benefits are lost upon entitlement to

early widow's or widower's insurance benefits.
Sec. 9117. Demonstration program to assist homeless individuals.
Sec. 9118. Assistance to homeless AFDC families.
Sec. 9119. Increase in personal needs allowance for SSI recipients.
Sec. 9120. Exclusion of death benefits to the extent spent on last illness and burial.
Sec. 9121. Demonstration of family independence program.
Sec. 9122. Child support demonstration program in New York state.
Sec. 9123. Technical correction.

PART 2—SOCIAL SERVICES, CHILD WELFARE SERVICES, AND OTHER PROVISIONS RELATING TO CHILDREN

Sec. 9131. Permanent extension of authority for voluntary foster care placements.
Sec. 9132. 2-year extension of foster care ceiling and of authority to transfer foster care funds to child welfare services.
Sec. 9133. Mother/infant foster care.
Sec. 9134. Increased funding for social services block grants.
Sec. 9135. Extension of social services block grant and child welfare services programs to American Samoa.
Sec. 9136. National commission on children.
Sec. 9137. Boarder babies demonstration project.
Sec. 9138. Study of infants and children with AIDS in foster care.
Sec. 9139. Technical corrections.

PART 3—CHILD SUPPORT ENFORCEMENT AMENDMENTS

Sec. 9141. Continuation of child support enforcement services to families no longer receiving AFDC.
Sec. 9142. Child support enforcement services required for certain families receiving Medicaid.
Sec. 9143. Repeal of unnecessary child support revolving fund.

PART 4—UNEMPLOYMENT COMPENSATION

Sec. 9151. Determination of amount of Federal share with respect to certain extended benefits payments.
Sec. 9152. Demonstration program to provide self-employment allowances for eligible individuals.
Sec. 9153. Extension of FUTA tax.
Sec. 9154. Transfer of funds into the Federal Unemployment Account and the Extended Unemployment Compensation Account.
Sec. 9155. Interest on advances to the Federal Unemployment Account and the Extended Unemployment Compensation Account.
Sec. 9156. Crediting to the Federal Unemployment Account of interest earned on advances by the States.

Subtitle C—Manufacturers Excise Tax on Certain Vaccines

Sec. 9201. Manufacturers excise tax on certain vaccines.
Sec. 9202. Vaccine Injury Compensation Trust Fund.

Subtitle D—Pension Provisions

PART I—FULL-FUNDING LIMITATIONS

Sec. 9301. Full-funding limitation for deductions to qualified plans.

PART II—PENSION FUNDING AND TERMINATION REQUIREMENTS

Sec. 9302. Short title; definitions.

SUBPART A—MODIFICATIONS OF MINIMUM FUNDING STANDARD

Sec. 9303. Additional funding requirements.
Sec. 9304. Time for making contributions.
Sec. 9305. Liability of members of controlled group for taxes on failure to meet minimum funding standards and to make minimum funding contributions.
Sec. 9307. Other funding changes.

SUBPART B—PLAN TERMINATIONS

Sec. 9311. Limitations on employer reversions upon plan termination.
Sec. 9312. Elimination of section 4049 trust: increase in liability to pension benefit

guaranty corporation and in payments by corporation to participants and beneficiaries.
Sec. 9313. Standards for termination.
Sec. 9314. Additional amendments relating to plan termination.

SUBPART C—INCREASE IN PREMIUM RATES

Sec. 9331. Increase in premium rates.

SUBPART D—MISCELLANEOUS PROVISIONS

Sec. 9341. Security required upon adoption of plan amendment resulting in significant underfunding.
Sec. 9342. Reporting requirements.
Sec. 9343. Coordination of provisions of the Internal Revenue Code of 1986 with provisions of the Employee Retirement Income Security Act of 1974.
Sec. 9344. Clarification regarding the imposition of an annual sanction for prohibited transactions which are continuing in nature.
Sec. 9345. Additional limitations on investment by an individual account plan forming part of a floor-offset arrangement and on investment by an individual account plan in employer stock.
Sec. 9346. Interest rate on accumulated contributions.

Subtitle E—Miscellaneous Provisions

Sec. 9401. Restoration of trust funds for 1987.
Sec. 9402. 6-month extension of provisions relating to collection of non-tax debts owed to Federal agencies.
Sec. 9403. Increase in limit on long-term bonds.

Subtitle F—Customs User Fees; Trade and Customs Authorizations

Sec. 9501. Customs user fees.
Sec. 9502. United States International Trade Commission authorizations.
Sec. 9503. United States Customs service authorizations.
Sec. 9504. Office of the United States Trade Representative authorizations.

Subtitle A—OASDI Provisions

PART 1—COVERAGE AND BENEFITS

SEC. 9001. COVERAGE OF INACTIVE DUTY MILITARY TRAINING.

(a) SOCIAL SECURITY ACT AMENDMENTS.—(1) Paragraph (1) of section 210(l) of the Social Security Act is amended to read as follows:

"(l)(1) Except as provided in paragraph (4), the term 'employment' shall, notwithstanding the provisions of subsection (a) of this section, include—

"(A) service performed after December 1956 by an individual as a member of a uniformed service on active duty, but such term shall not include any such service which is performed while on leave without pay, and

"(B) service performed after December 1987 by an individual as a member of a uniformed service on inactive duty training.".

(2) The second indented paragraph following subsection (s) in section 209 of such Act (relating to service in the uniformed services) is amended by striking "only his basic pay" and all that follows and inserting "only (1) his basic pay as described in chapter 3 and section 1009 of title 37, United States Code, in the case of an individual performing service to which subparagraph (A) of such section 210(l)(1) applies, or (2) his compensation for such service as determined under section 206(a) of title 37, United States Code, in the

case of an individual performing service to which subparagraph (B) of such section 210(l)(1) applies.".

(b) FICA AMENDMENTS.—(1) Paragraph (1) of section 3121(m) of the Internal Revenue Code of 1986 (relating to inclusion of service in the uniformed services) is amended to read as follows:

"(1) INCLUSION OF SERVICE.—The term 'employment' shall, notwithstanding the provisions of subsection (b) of this section, include—

"(A) service performed by an individual as a member of a uniformed service on active duty, but such term shall not include any such service which is performed while on leave without pay, and

"(B) service performed by an individual as a member of a uniformed service on inactive duty training.".

(2) Paragraph (2) of section 3121(i) of such Code (relating to computation of wages for individuals performing service in the uniformed services) is amended by striking "only his basic pay" and all that follows and inserting "only (A) his basic pay as described in chapter 3 and section 1009 of title 37, United States Code, in the case of an individual performing service to which subparagraph (A) of such subsection (m)(1) applies, or (B) his compensation for such service as determined under section 206(a) of title 37, United States Code, in the case of an individual performing service to which subparagraph (B) of such subsection (m)(1) applies.".

(c) CONFORMING AMENDMENT.—Section 229(a) of the Social Security Act is amended by striking "section 210(l)" and inserting "210(l)(1)(A)".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to remuneration paid after December 31, 1987.

SEC. 9002. COVERAGE OF ALL CASH PAY OF AGRICULTURAL EMPLOYEES WHOSE EMPLOYERS SPEND $2,500 OR MORE A YEAR FOR AGRICULTURAL LABOR.

(a) SOCIAL SECURITY ACT AMENDMENT.—Paragraph (2) of section 209(h) of the Social Security Act is amended by striking clause (B) and inserting "(B) the employer's expenditures for agricultural labor in such year equal or exceed $2,500;".

(b) FICA AMENDMENT.—Subparagraph (B) of section 3121(a)(8) of the Internal Revenue Code of 1986 (relating to wages) is amended by striking clause (ii) and inserting "(ii) the employer's expenditures for agricultural labor in such year equal or exceed $2,500;".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to remuneration for agricultural labor paid after December 31, 1987.

SEC. 9003. COVERAGE OF THE EMPLOYER COST OF GROUP-TERM LIFE INSURANCE.

(a) COVERAGE UNDER OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE PROGRAM.—

(1) SOCIAL SECURITY ACT AMENDMENT.—Clause (3) of section 209(b) of the Social Security Act is amended by striking "death" and inserting "death, except that this subsection does not apply to a payment for group-term life insurance to the extent that

such payment is includible in the gross income of the employee under the Internal Revenue Code of 1986".

(2) FICA AMENDMENT.—Subparagraph (C) of section 3121(a)(2) of the Internal Revenue Code of 1986 (relating to wages) is amended by striking "death" and inserting "death, except that this paragraph does not apply to a payment for group-term life insurance to the extent that such payment is includible in the gross income of the employee".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to group-term life insurance coverage in effect after December 31, 1987.

SEC. 9004. COVERAGE OF SERVICES PERFORMED BY ONE SPOUSE IN THE EMPLOY OF THE OTHER.

(a) SOCIAL SECURITY ACT AMENDMENTS.—

(1) IN GENERAL.—Subparagraph (A) of section 210(a)(3) of the Social Security Act is amended by striking "performed by an individual in the employ of his spouse, and service".

(2) EXCEPTION FOR CERTAIN DOMESTIC SERVICE IN THE PRIVATE HOME OF A SPOUSE.—Paragraph (3) of section 210(a) of such Act is amended by striking so much of subparagraph (B) as precedes clause (i) and inserting the following:

"(B) Service not in the course of the employer's trade or business, or domestic service in a private home of the employer, performed by an individual in the employ of his spouse or son or daughter; except that the provisions of this subparagraph shall not be applicable to such domestic service performed by an individual in the employ of his son or daughter if—".

(b) FICA AMENDMENTS.—

(1) IN GENERAL.—Subparagraph (A) of section 3121(b)(3) of the Internal Revenue Code of 1986 (relating to employment) is amended by striking "performed by an individual in the employ of his spouse, and service".

(2) EXCEPTION FOR CERTAIN DOMESTIC SERVICE IN THE PRIVATE HOME OF A SPOUSE.—Paragraph (3) of section 3121(b) of such Code (relating to employment) is amended by striking so much of subparagraph (B) as precedes clause (i) and inserting the following:

"(B) service not in the course of the employer's trade or business, or domestic service in a private home of the employer, performed by an individual in the employ of his spouse or son or daughter; except that the provisions of this subparagraph shall not be applicable to such domestic service performed by an individual in the employ of his son or daughter if—".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to remuneration paid after December 31, 1987.

SEC. 9005. TREATMENT OF SERVICE PERFORMED BY AN INDIVIDUAL IN THE EMPLOY OF A PARENT.

(a) SOCIAL SECURITY ACT AMENDMENTS.—

(1) AGE BELOW WHICH SERVICE FOR PARENT IS EXCLUDED FROM COVERED EMPLOYMENT REDUCED TO AGE 18.—Subparagraph (A) of section 210(a)(3) of the Social Security Act (as amended by section 9004(a)(1) of this Act) is further amended by striking "twenty-one" and inserting "18".

(2) EXCEPTION FOR CERTAIN DOMESTIC SERVICE IN THE PRIVATE HOME OF PARENT.—Subparagraph (B) of section 210(a)(3) of such Act (as amended by section 9004(a)(2) of this Act) is further amended by inserting "under the age of 21 in the employ of his father or mother, or performed by an individual" after "individual" the first place it appears.

(b) FICA AMENDMENTS.—

(1) AGE BELOW WHICH SERVICE FOR PARENT IS EXCLUDED FROM COVERED EMPLOYMENT REDUCED TO AGE 18.—Subparagraph (A) of section 3121(b)(3) of the Internal Revenue Code of 1986 (as amended by section 9004(b)(1) of this Act) is further amended by striking "21" and inserting "18".

(2) EXCEPTION FOR CERTAIN DOMESTIC SERVICE IN THE PRIVATE HOME OF PARENT.—Subparagraph (B) of section 3121(b)(3) of such Code (as amended by section 9004(b)(2) of this Act) is further amended by inserting "under the age of 21 in the employ of his father or mother, or performed by an individual" after "individual" the first place it appears.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to remuneration paid after December 31, 1987.

SEC. 9006. APPLICATION OF EMPLOYER TAXES TO EMPLOYEES' CASH TIPS.

(a) APPLICATION OF TAX TO TIPS.—Section 3121(q) of the Internal Revenue Code of 1986 (relating to inclusion of tips for employee taxes) is amended—

(1) by striking "EMPLOYEE TAXES" in the heading and inserting "BOTH EMPLOYEE AND EMPLOYER TAXES":

(2) by striking "other than for purposes of the taxes imposed by section 3111";

(3) by striking "remuneration for employment" and inserting "remuneration for such employment (and deemed to have been paid by the employer for purposes of subsections (a) and (b) of section 3111)"; and

(4) by inserting after "at the time received" the following: "; except that, in determining the employer's liability in connection with the taxes imposed by section 3111 with respect to such tips in any case where no statement including such tips was so furnished (or to the extent that the statement so furnished was inaccurate or incomplete), such remuneration shall be deemed for purposes of subtitle F to be paid on the date on which notice and demand for such taxes is made to the employer by the Secretary".

(b) CONFORMING AMENDMENTS.—(1) Subsections (a) and (b) of section 3111(a) of such Code (relating to rate of tax on employers) are each amended by striking "and (t)".

(2) Section 3121(t) of such Code (relating to special rule) is repealed.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to tips received (and wages paid) on and after January 1, 1988.

SEC. 9007. APPLICABILITY OF GOVERNMENT PENSION OFFSET TO CERTAIN FEDERAL EMPLOYEES.

(a) WIFE'S INSURANCE BENEFITS.—Paragraph (4) of section 202(b) of the Social Security Act is amended—

(1) by redesignating subparagraph (B) as subparagraph (C); and

(2) by striking subparagraph (A) and inserting the following:

"(A) The amount of a wife's insurance benefit for each month (as determined after application of the provisions of subsections (q) and (k)) shall be reduced (but not below zero) by an amount equal to two-thirds of the amount of any monthly periodic benefit payable to the wife (or divorced wife) for such month which is based upon her earnings while in the service of the Federal Government or any State (or political subdivision thereof, as defined in section 218(b)(2)) if, on the last day she was employed by such entity—

"(i) such service did not constitute 'employment' as defined in section 210, or

"(ii) such service was being performed while in the service of the Federal Government, and constituted 'employment' as so defined solely by reason of—

"(I) clause (ii) or (iii) of subparagraph (G) of section 210(a)(5), where the lump-sum payment described in such clause (ii) or the cessation of coverage described in such clause (iii) (whichever is applicable) was received or occurred on or after January 1, 1988, or

"(II) an election to become subject to chapter 84 of title 5, United States Code, made pursuant to law after December 31, 1987,

unless subparagraph (B) applies.

The amount of the reduction in any benefit under this subparagraph, if not a multiple of $0.10, shall be rounded to the next higher multiple of $0.10.

"(B) Subparagraph (A)(ii) shall not apply with respect to monthly periodic benefits based in whole or in part on service which constituted 'employment' as defined in section 210 if such service was performed for at least 60 months in the aggregate during the period beginning January 1, 1988, and ending with the close of the first calendar month as of the end of which the wife (or divorced wife) is eligible for benefits under this subsection and has made a valid application for such benefits.".

(b) HUSBAND'S INSURANCE BENEFITS.—Paragraph (2) of section 202(c) of such Act is amended—

(1) by redesignating subparagraph (B) as subparagraph (C); and

(2) by striking subparagraph (A) and inserting the following:

"(A) The amount of a husband's insurance benefit for each month (as determined after application of the provisions of subsections (q) and (k)) shall be reduced (but not below zero) by an amount equal to two-thirds of the amount of any monthly periodic benefit payable to the husband (or divorced husband) for such month which is based upon his earnings while in the service of the Federal Government or any State (or political subdivision thereof, as defined in section 218(b)(2)) if, on the last day he was employed by such entity—

"(i) such service did not constitute 'employment' as defined in section 210, or

"(ii) such service was being performed while in the service of the Federal Government, and constituted 'employment' as so defined solely by reason of—

"(I) clause (ii) or (iii) of subparagraph (G) of section 210(a)(5), where the lump-sum payment described in such clause (ii) or the cessation of coverage described in such clause (iii) (whichever is applicable) was received or occurred on or after January 1, 1988, or

"(II) an election to become subject to chapter 84 of title 5, United States Code, made pursuant to law after December 31, 1987,

unless subparagraph (B) applies.

The amount of the reduction in any benefit under this subparagraph, if not a multiple of $0.10, shall be rounded to the next higher multiple of $0.10.

"(B) Subparagraph (A)(ii) shall not apply with respect to monthly periodic benefits based in whole or in part on service which constituted 'employment' as defined in section 210 if such service was performed for at least 60 months in the aggregate during the period beginning January 1, 1988, and ending with the close of the first calendar month as of the end of which the husband (or divorced husband) is eligible for benefits under this subsection and has made a valid application for such benefits.".

(c) WIDOW'S INSURANCE BENEFITS.—Paragraph (7) of section 202(e) of such Act is amended—

(1) by redesignating subparagraph (B) as subparagraph (C); and

(2) by striking subparagraph (A) and inserting the following:

"(A) The amount of a widow's insurance benefit for each month (as determined after application of the provisions of subsections (q) and (k), paragraph (2)(D), and paragraph (3)) shall be reduced (but not below zero) by an amount equal to two-thirds of the amount of any monthly periodic benefit payable to the widow (or surviving divorced wife) for such month which is based upon her earnings while in the service of the Federal Government or any State (or political subdivision thereof, as defined in section 218(b)(2)) if, on the last day she was employed by such entity—

"(i) such service did not constitute 'employment' as defined in section 210, or

"(ii) such service was being performed while in the service of the Federal Government, and constituted 'employment' as so defined solely by reason of—

"(I) clause (ii) or (iii) of subparagraph (G) of section 210(a)(5), where the lump-sum payment described in such clause (ii) or the cessation of coverage described in such clause (iii) (whichever is applicable) was received or occurred on or after January 1, 1988, or

"(II) an election to become subject to chapter 84 of title 5, United States Code, made pursuant to law after December 31, 1987,

unless subparagraph (B) applies.

The amount of the reduction in any benefit under this subparagraph, if not a multiple of $0.10, shall be rounded to the next higher multiple of $0.10.

"(B) Subparagraph (A)(ii) shall not apply with respect to monthly periodic benefits based in whole or in part on service which constituted 'employment' as defined in section 210 if such service was per-

formed for at least 60 months in the aggregate during the period beginning January 1, 1988, and ending with the close of the first calendar month as of the end of which the widow (or surviving divorced wife) is eligible for benefits under this subsection and has made a valid application for such benefits.".

(d) WIDOWER'S INSURANCE BENEFITS.—Paragraph (2) of section 202(f) of such Act is amended—

(1) by redesignating subparagraph (B) as subparagraph (C); and

(2) by striking subparagraph (A) and inserting the following:

"(A) The amount of a widower's insurance benefit for each month (as determined after application of the provisions of subsections (q) and (k), paragraph (3)(D), and paragraph (4)) shall be reduced (but not below zero) by an amount equal to two-thirds of the amount of any monthly periodic benefit payable to the widower (or surviving divorced husband) for such month which is based upon his earnings while in the service of the Federal Government or any State (or political subdivision thereof, as defined in section 218(b)(2)) if, on the last day he was employed by such entity—

"(i) such service did not constitute 'employment' as defined in section 210, or

"(ii) such service was being performed while in the service of the Federal Government, and constituted 'employment' as so defined solely by reason of—

"(I) clause (ii) or (iii) of subparagraph (G) of section 210(a)(5), where the lump-sum payment described in such clause (ii) or the cessation of coverage described in such clause (iii) (whichever is applicable) was received or occurred on or after January 1, 1988, or

"(II) an election to become subject to chapter 84 of title 5, United States Code, made pursuant to law after December 31, 1987,

unless subparagraph (B) applies.

The amount of the reduction in any benefit under this subparagraph, if not a multiple of $0.10, shall be rounded to the next higher multiple of $0.10.

"(B) Subparagraph (A)(ii) shall not apply with respect to monthly periodic benefits based in whole or in part on service which constituted 'employment' as defined in section 210 if such service was performed for at least 60 months in the aggregate during the period beginning January 1, 1988, and ending with the close of the first calendar month as of the end of which the widower (or surviving divorced husband) is eligible for benefits under this subsection and has made a valid application for such benefits.".

(e) MOTHER'S AND FATHER'S INSURANCE BENEFITS.—Paragraph (4) of section 202(g) of such Act is amended—

(1) by redesignating subparagraph (B) as subparagraph (C); and

(2) by striking subparagraph (A) and inserting the following:

"(A) The amount of a mother's or father's insurance benefit for each month (as determined after application of the provisions of subsection (k)) shall be reduced (but not below zero) by an amount equal to two-thirds of the amount of any monthly periodic benefit payable to the individual for such month which is based upon the

individual's earnings while in the service of the Federal Government or any State (or political subdivision thereof, as defined in section 218(b)(2)) if, on the last day the individual was employed by such entity—

"(i) such service did not constitute 'employment' as defined in section 210, or

"(ii) such service was being performed while in the service of the Federal Government, and constituted 'employment' as so defined solely by reason of—

"(I) clause (ii) or (iii) of subparagraph (G) of section 210(a)(5), where the lump-sum payment described in such clause (ii) or the cessation of coverage described in such clause (iii) (whichever is applicable) was received or occurred on or after January 1, 1988, or

"(II) an election to become subject to chapter 84 of title 5, United States Code, made pursuant to law after December 31, 1987,

unless subparagraph (B) applies.

The amount of the reduction in any benefit under this subparagraph, if not a multiple of $0.10, shall be rounded to the next higher multiple of $0.10.

"(B) Subparagraph (A)(ii) shall not apply with respect to monthly periodic benefits based in whole or in part on service which constituted 'employment' as defined in section 210 if such service was performed for at least 60 months in the aggregate during the period beginning January 1, 1988, and ending with the close of the first calendar month as of the end of which the individual is eligible for benefits under this subsection and has made a valid application for such benefits.".

(f) EFFECTIVE DATE.—The amendments made by this section shall apply only with respect to benefits for months after December 1987; except that nothing in such amendments shall affect any exemption (from the application of the pension offset provisions contained in subsection (b)(4), (c)(2), (e)(7), (f)(2), or (g)(4) of section 202 of the Social Security Act) which any individual may have by reason of subsection (g) or (h) of section 334 of the Social Security Amendments of 1977.

SEC. 9008. MODIFICATION OF AGREEMENT WITH IOWA TO PROVIDE COVERAGE FOR CERTAIN POLICEMEN AND FIREMEN.

(a) IN GENERAL.—Notwithstanding subsection (d)(5)(A) of section 218 of the Social Security Act and the references thereto in subsections (d)(1) and (d)(3) of such section 218, the agreement with the State of Iowa heretofore entered into pursuant to such section 218 may, at any time prior to January 1, 1989, be modified pursuant to subsection (c)(4) of such section 218 so as to apply to services performed in policemen's or firemen's positions required to be covered by a retirement system pursuant to section 410.1 of the Iowa Code as in effect on July 1, 1953, if the State of Iowa has at any time prior to the date of the enactment of this Act paid to the Secretary of the Treasury, with respect to any of the services performed in such positions, the sums prescribed pursuant to subsection (e)(1) of such section 218 (as in effect on December 31, 1986, with respect to payments due with respect to wages paid on or before such date).

(b) SERVICE TO BE COVERED.—Notwithstanding the provisions of subsection (e) of section 218 of the Social Security Act (as so redesignated by section 9002(c)(1) of the Omnibus Budget Reconciliation Act of 1986)), any modification in the agreement with the State of Iowa under subsection (a) shall be made effective with respect to—

(1) all services performed in any policemen's or firemen's position to which the modification relates on or after January 1, 1987, and

(2) all services performed in such a position before January 1, 1987, with respect to which the State of Iowa has paid to the Secretary of the Treasury the sums prescribed pursuant to subsection (e)(1) of such section 218 (as in effect on December 31, 1986, with respect to payments due with respect to wages paid on or before such date) at the time or times established pursuant to such subsection (e)(1), if and to the extent that—

(A) no refund of the sums so paid has been obtained, or

(B) a refund of part or all of the sums so paid has been obtained but the State of Iowa repays to the Secretary of the Treasury the amount of such refund within 90 days after the date on which the modification is agreed to by the State and the Secretary of Health and Human Services.

SEC. 9009. CONTINUATION OF DISABILITY BENEFITS DURING APPEAL.

Subsection (g) of section 223 of the Social Security Act is amended—

(1) in paragraph (1)(iii), by striking "June 1988" and inserting "June 1989"; and

(2) in paragraph (3)(B), by striking "January 1, 1988" and inserting "January 1, 1989".

SEC. 9010. EXTENSION OF DISABILITY RE-ENTITLEMENT PERIOD FROM 15 MONTHS TO 36 MONTHS.

(a) DISABILITY INSURANCE BENEFITS.—Paragraph (1) of section 223(a) of the Social Security Act is amended by striking "15 months" and inserting "36 months".

(b) CHILD'S INSURANCE BENEFITS BASED ON DISABILITY.—Clause (i) of section 202(d)(1)(G) of such Act is amended by striking "15 months" and inserting "36 months".

(c) WIDOW'S INSURANCE BENEFITS BASED ON DISABILITY.—Paragraph (1) of section 202(e) of such Act is amended, in subclause (II) of the last sentence, by striking "15 months" and inserting "36 months".

(d) WIDOWER'S INSURANCE BENEFITS BASED ON DISABILITY.—Paragraph (1) of section 202(f) of such Act is amended, in subclause (II) of the last sentence, by striking "15 months" and inserting "36 months".

(e) CONFORMING AMENDMENTS.—

(1) TERMINATION OF PERIOD OF DISABILITY.—Subparagraph (D) of section 216(i)(2) of such Act is amended by striking "15-month" and inserting "36-month".

(2) TERMINATION OF BENEFITS DURING RE-ENTITLEMENT PERIOD.—Subsection (e) of section 223 of such Act is amended by striking "15-month" and inserting "36-month".

(3) SPECIAL RULE FOR DETERMINATION OF CONTINUED MEDICARE ELIGIBILITY BASED ON ENTITLEMENT TO DISABILITY BENE-

FITS.—Section 226(b) of such Act is amended by adding at the end the following new sentence: "In determining when an individual's entitlement or status terminates for purposes of the preceding sentence, the second sentence of section 223(a) shall be applied as though the term '36 months' (in such second sentence) read '15 months'.".

(f) EFFECTIVE DATE.—The amendments made by this section shall take effect January 1, 1988, and shall apply with respect to—

(1) individuals who are entitled to benefits which are payable under subsection (d)(1)(B)(ii), (d)(6)(A)(ii), (d)(6)(B), (e)(1)(B)(ii), or (f)(1)(B)(ii) of section 202 of the Social Security Act or subsection (a)(1) of section 223 of such Act for any month after December 1987, and

(2) individuals who are entitled to benefits which are payable under any provision referred to in paragraph (1) for any month before January 1988 and with respect to whom the 15-month period described in the applicable provision amended by this section has not elapsed as of January 1, 1988.

PART 2—OTHER SOCIAL SECURITY PROVISIONS

SEC. 9021. MORATORIUM ON REDUCTIONS IN ATTORNEYS' FEES; STUDIES OF ATTORNEYS' FEE PAYMENT SYSTEM.

(a) MORATORIUM.—(1) The provisions of the memorandum of the Associate Commissioner of Social Security dated March 31, 1987 (relating to revised delegations of authority for administrative law judges to determine fees of representatives) which amend sections 1-220 through 1-226 of the Office of Hearings and Appeals Staff Guides and Programs Digest (commonly referred to as the OHA Handbook), and Interim Circular No. 122 (relating to the determination authority regarding fees for representation of claimants), are hereby declared to be null and void. The preceding sentence shall apply with respect to all attorneys' fees finally authorized in connection with claims for benefits under title II of the Social Security Act on and after the date of the enactment of this Act, regardless of when the legal services involved were performed; and no reconsideration of any such fee finally authorized prior to that date shall be required.

(2) Until July 1, 1989, neither the Secretary nor the Social Security Administration may modify any of the rules and regulations relating to attorneys' fees in connection with claims for benefits under title II of the Social Security Act.

(b) STUDIES.—(1) The Secretary of Health and Human Services shall conduct a study of the attorneys' fee payment process under title II of the Social Security Act. Such study shall—

(A) assess the levels of reimbursement to attorneys, giving consideration to the contingent nature of most arrangements between claimants and their legal representatives, and propose alternative methods for establishing fees which take the nature of these arrangements into account, and

(B) suggest changes aimed at eliminating unnecessary delays in the approval and payment of attorneys' fees and thereby streamlining the payment process.

In conducting this study, the Secretary shall consult with individuals who represent the views of attorneys and with others who represent the views of claimants.

(2) At the same time, the Comptroller General shall conduct a study of the fee approval system, including at a minimum—

(A) a study of the impact of the current system on claimants and attorneys,

(B) an identification of obstacles to the timely payment of attorneys' fees under present law, and

(C) an assessment of the effect, if any, which the reduced limit on attorneys' fees in effect immediately prior to the enactment of this Act has had on access to legal representation by applicants for disability insurance benefits.

(3) The studies required by paragraphs (1) and (2), along with any recommendations resulting therefrom, shall be submitted to the Congress no later than July 1, 1988.

SEC. 9022. CORPORATE DIRECTORS.

(a) SOCIAL SECURITY ACT AMENDMENT.—Section 211(a) of the Social Security Act is amended by adding at the end thereof the following new paragraph:

"Any income of an individual which results from or is attributable to the performance of services by such individual as a director of a corporation during any taxable year shall be deemed to have been derived (and received) by such individual in that year, at the time the services were performed, regardless of when the income is actually paid to or received by such individual (unless it was actually paid and received prior to that year).".

(b) SECA AMENDMENT.—Section 1402(a) of the Internal Revenue Code of 1986 (relating to definition of net earnings from self-employment) is amended by adding at the end thereof the following new paragraph:

"Any income of an individual which results from or is attributable to the performance of services by such individual as a director of a corporation during any taxable year shall be deemed to have been derived (and received) by such individual in that year, at the time the services were performed, regardless of when the income is actually paid to or received by such individual (unless it was actually paid and received prior to that year).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services performed in taxable years beginning on or after January 1, 1988.

SEC. 9023. TECHNICAL CORRECTIONS.

(a) The heading of section 210(p) of the Social Security Act is amended to read as follows:

"Medicare Qualified Government Employment".

(b)(1) Section 211(a)(7) of such Act is amended—

(A) by inserting "and" before "section 911"; and

(B) by striking "and section 931 (relating to income from sources within possessions of the United States) of the Internal Revenue Code of 1954".

(2) Section 211(a)(8) of such Act is amended to read as follows:

"(8) The exclusion from gross income provided by section 931 of the Internal Revenue Code of 1986 shall not apply;".

(c) Section 218(v) of such Act is amended—

(1) by striking "(v)" and inserting "(n)";

(2) by striking paragraph (3); and

(3) by redesignating paragraphs (4) and (5) as paragraphs (3) and (4), respectively.

(d) Section 3121(a)(5) of the Internal Revenue Code of 1986 is amended—

(1) by striking "; or" at the end of subparagraph (F) and inserting ", or"; and

(2) by striking the comma at the end of subparagraph (G) and inserting a semicolon.

PART 3—RAILROAD RETIREMENT PROGRAM

SEC. 9031. INCREASE IN RATES OF TIER 2 RAILROAD RETIREMENT TAX ON EMPLOYEES FOR 1988 AND THEREAFTER.

(a) IN GENERAL.—Subsection (b) of section 3201 of the Internal Revenue Code of 1986 (relating to tier 2 employee tax) is amended to read as follows:

"(b) TIER 2 TAX.—In addition to other taxes, there is hereby imposed on the income of each employee a tax equal to 4.90 percent of the compensation received during any calendar year by such employee for services rendered by such employee.".

(b) EFFECTIVE DATE.—The amendment made by this section shall apply with respect to compensation received after December 31, 1987.

SEC. 9032. INCREASE IN RATES OF TIER 2 RAILROAD RETIREMENT TAX ON EMPLOYERS FOR 1988 AND THEREAFTER.

(a) IN GENERAL.—Subsection (b) of section 3221 of the Internal Revenue Code of 1986 (relating to tier 2 employer tax) is amended to read as follows:

"(b) TIER 2 TAX.—In addition to other taxes, there is hereby imposed on every employer an excise tax, with respect to having individuals in his employ, equal to 16.10 percent of the compensation paid during any calendar year by such employer for services rendered to such employer.".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to compensation paid after December 31, 1987.

SEC. 9033. COMMISSION ON RAILROAD RETIREMENT REFORM.

(a) COMMISSION ON RAILROAD RETIREMENT REFORM.—There is established a commission to be known as the Commission on Railroad Retirement Reform (in this section referred to as the "Commission").

(b) STUDY.—The Commission shall conduct a comprehensive study of the issues pertaining to the long-term financing of the railroad retirement system (in this section referred to as the "system") and the system's short-term and long-term solvency. The Commission shall submit a report containing a detailed statement of its findings and conclusions together with recommendations to the Congress for revisions in, or alternatives to, the current system to assure the provision of retirement benefits to former, present, and future railroad employees on an actuarially sound basis. The study will take into account—

(1) the possibility of restructuring the financing of railroad retirement benefits through increases in the tier 2 tax rate, increases in the tier 2 tax wage base, the imposition of a tax on operating revenues, revisions in the investment policy of the railroad retirement pension fund, and establishing a privately funded and administered railroad industry pension plan;

(2) the economic outlook for the railroad industry, and the nature of the relationships between the railroad retirement system, levels of railroad employment and compensation, and the performance of the rail sector;

(3) the ability of the system under current law to pay benefits to current and future retirees and other beneficiaries;

(4) the financial relationship of the system to the railroad unemployment insurance system, the social security system, and the General Fund; and

(5) any other matters which the Commission considers would be necessary, appropriate, or useful to the Congress in developing legislation to reform the system.

(c) MEMBERSHIP OF THE COMMISSION.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of seven members, as follows:

(A) four individuals appointed by the President—

(i) one of whom shall be appointed on the basis of recommendations made by representatives of employers (as defined in section 1(a) of the Railroad Retirement Act of 1974) so as to provide representation on the Commission satisfactory to the largest number of employers concerned,

(ii) one of whom shall be appointed on the basis of recommendations made by representatives of employees (as defined in section 1(b) of the Railroad Retirement Act of 1974) so as to provide representation on the Commission satisfactory to the largest number of employees concerned,

(iii) one of whom shall be appointed on the basis of recommendations made by representatives of commuter railroads, and

(iv) one of whom shall be appointed from members of the public;

(B) one individual appointed by the Speaker of the House of Representatives from among members of the public;

(C) one individual appointed by the President pro tempore of the Senate from among members of the public; and

(D) one individual appointed by the Comptroller General from among members of the public with expertise in the fields of retirement systems and pension plans.

All public members of the Commission shall be appointed from among individuals who are not in the employment of and are not pecuniarily or otherwise interested in any employer (as so defined) or organization of employees (as so defined). In making appointments under this section, the President, the Speaker of the House of Representatives, and the President pro tempore of the Senate shall ensure that the members of the Commission, collectively, possess special knowledge of retirement income

policy, social insurance, private pensions, taxation, and the structure of the transportation industry. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(2) PAY.—Members of the Commission shall serve without compensation, but shall be reimbursed for travel, subsistence, and other necessary expenses incurred in the performance of their duties as members of the Commission.

(3) QUORUM.—Five members of the Commission shall constitute a quorum but a lesser number may hold hearings.

(4) CHAIRMAN.—The members of the Commission shall elect a chairman from among the membership.

(d) STAFF OF COMMISSION; EXPERTS AND CONSULTANTS.—

(1) STAFF.—Subject to such rules as may be prescribed by the Commission, the Chairman may appoint and fix the pay of such personnel as the Chairman considers appropriate.

(2) APPLICABILITY OF CERTAIN CIVIL SERVICE LAWS.—The staff of the Commission may be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and may be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title relating to classification and General Schedule pay rates, except that no individual so appointed may receive pay in excess of the annual rate of basic pay payable for GS-18 of the General Schedule.

(3) EXPERTS AND CONSULTANTS.—Subject to such rules as may be prescribed by the Commission, the Chairman may procure temporary and intermittent services under section 3109(b) of title 5 of the United States Code, but at rates for individuals not to exceed the daily equivalent of the maximum annual rate of basic pay payable for GS-18 of the General Schedule.

(4) STAFF OF FEDERAL AGENCIES.—Upon request of the Commission, the Railroad Retirement Board and any other Federal agency may detail, on a reimbursable basis, any of the personnel thereof to the Commission to assist the Commission in carrying out its duties under this section.

(e) ACCESS TO OFFICIAL DATA AND SERVICES.—

(1) OFFICIAL DATA.—The Commission may, as appropriate, secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairman of the Commission, the head of such department or agency shall, as appropriate, furnish such information to the Commission.

(2) MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as other departments and agencies of the United States.

(3) ADMINISTRATIVE SUPPORT SERVICES.—The Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

(f) REPORT.—The Commission shall transmit a report to the President and to each House of the Congress not later than October 1, 1989. The report shall contain a detailed statement of the findings

and conclusions of the Commission, together with its legislative recommendations.

(g) TERMINATION.—The Commission shall cease to exist 60 days after submitting its report pursuant to subsection (f).

(h) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated the sum of $1,000,000 for purposes of this section, to remain available until expended but in no event beyond the date of termination provided in subsection (g).

SEC. 9034. TRANSFER TO RAILROAD RETIREMENT ACCOUNT.

Subsection (c)(1)(A) of section 224 of the Railroad Retirement Solvency Act of 1983 (relating to section 72(r) revenue increase transferred to certain railroad accounts) is amended—

(1) by inserting "(other than amounts described in subparagraph (B))" after "amounts";

(2) by striking "1988" and inserting "1989"; and

(3) by striking the last sentence.

Subtitle B—Provisions Relating to Public Assistance and Unemployment Compensation

PART 1—AFDC AND SSI AMENDMENTS

SEC. 9101. PERMANENT EXTENSION OF DISREGARD OF NONPROFIT ORGANIZATIONS' IN-KIND ASSISTANCE TO SSI AND AFDC RECIPIENTS.

Effective as of October 1, 1987, section 2639(d) of the Deficit Reduction Act of 1984 is amended by striking "; but" and all that follows and inserting a period.

SEC. 9102. FRAUD CONTROL UNDER AFDC PROGRAM.

(a) IN GENERAL.—Part A of title IV of the Social Security Act is amended by adding at the end the following new section:

"FRAUD CONTROL

"SEC. 416. (a) Any State, in the administration of its State plan approved under section 402, may elect to establish and operate a fraud control program in accordance with this section.

"(b) Under any such program, if an individual who is a member of a family applying for or receiving aid under the State plan approved under section 402 is found by a Federal or State court or pursuant to an administrative hearing meeting requirements determined in regulations of the Secretary, on the basis of a plea of guilty or nolo contendere or otherwise, to have intentionally—

"(1) made a false or misleading statement or misrepresented, concealed, or withheld facts, or

"(2) committed any act intended to mislead, misrepresent, conceal, or withhold facts or propound a falsity,

for the purpose of establishing or maintaining the family's eligibility for aid under such State plan or of increasing (or preventing a reduction in) the amount of such aid, then the needs of such individual shall not be taken into account in making the determination under section 402(a)(7) with respect to his or her family (A) for a period of 6 months upon the first occasion of any such offense, (B) for a period of 12 months upon the second occasion of any such of-

fense, and (C) permanently upon the third or a subsequent occasion of any such offense.

"(c) The State agency involved shall proceed against any individual alleged to have committed an offense described in subsection (b) either by way of administrative hearing or by referring the matter to the appropriate authorities for civil or criminal action in a court of law. The State agency shall coordinate its actions under this section with any corresponding actions being taken under the food stamp program in any case where the factual issues involved arise from the same or related circumstances.

"(d) Any period for which sanctions are imposed under subsection (b) shall remain in effect, without possibility of administrative stay, unless and until the finding upon which the sanctions were imposed is subsequently reversed by a court of appropriate jurisdiction; but in no event shall the duration of the period for which such sanctions are imposed be subject to review.

"(e) The sanctions provided under subsection (b) shall be in addition to, and not in substitution for, any other sanctions which may be provided for by law with respect to the offenses involved.

"(f) Each State which has elected to establish and operate a fraud control program under this section must provide all applicants for aid to families with dependent children under its approved State plan, at the time of their application for such aid, with a written notice of the penalties for fraud which are provided for under this section.".

(b) STATE PLAN REQUIREMENT.—Section 402(a) of such Act is amended—

(1) by striking "and" after the semicolon at the end of paragraph (38);

(2) by striking the period at the end of paragraph (39) and inserting "; and"; and

(3) by inserting immediately after paragraph (39) the following new paragraph:

"(40) provide, if the State has elected to establish and operate a fraud control program under section 416, that the State will submit to the Secretary (with such revisions as may from time to time be necessary) a description of and budget for such program, and will operate such program in full compliance with that section.".

(c) FEDERAL MATCHING.—Section 403(a)(3) of such Act is amended—

(1) by striking "and" after the final comma in subparagraph (B);

(2) by redesignating subparagraph (C) as subparagraph (D);

(3) by inserting after subparagraph (B) the following new subparagraph:

"(C) 75 percent of so much of such expenditures as are for the costs of carrying out a fraud control program under section 416, including costs related to the investigation, prosecution, and administrative hearing of fraudulent cases and the making of any resultant collections, and"; and

(4) by striking "(C)" in the matter following subparagraph (D) (as redesignated by paragraph (2) of this subsection) and inserting "(D)".

(d) EFFECTIVE DATE.—The amendments made by this section shall become effective April 1, 1988.

SEC. 9103. EXCLUSION OF REAL PROPERTY WHEN IT CANNOT BE SOLD.

(a) IN GENERAL.—Section 1613(b) of the Social Security Act is amended—

(1) by inserting "(1)" after "(b)"; and

(2) by adding at the end the following new paragraph:

"(2) Notwithstanding the provisions of paragraph (1), the Secretary shall not require the disposition of any real property for so long as it cannot be sold because (A) it is jointly owned (and its sale would cause undue hardship, due to loss of housing, for the other owner or owners), (B) its sale is barred by a legal impediment, or (C) as determined under regulations issued by the Secretary, the owner's reasonable efforts to sell it have been unsuccessful.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall become effective April 1, 1988.

SEC. 9104. ADJUSTMENT OF PENALTY WHERE ASSET IS TRANSFERRED FOR LESS THAN FAIR MARKET VALUE.

(a) IN GENERAL.—Section 1613(c) of the Social Security Act is amended—

(1) by inserting immediately after "the exclusions under subsection (a)" in paragraph (1) the following: ", and subject to paragraph (4) of this subsection"; and

(2) by adding at the end the following new paragraph:

"(4) The Secretary shall by regulation provide for suspending the application of paragraph (1) to the extent (in any instance) that the Secretary determines that such suspension is necessary to avoid undue hardship.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall become effective April 1, 1988.

SEC. 9105. EXCLUSION OF INTEREST ON BURIAL ACCOUNTS.

(a) IN GENERAL.—Section 1613(d) of the Social Security Act is amended—

(1) in paragraph (1), by striking "if the inclusion" and all that follows and inserting a period; and

(2) in paragraph (3), by striking "aside" and inserting "aside in cases where the inclusion of any portion of the amount would cause the resources of such individual, or of such individual and spouse, to exceed the limits specified in paragraph (1) or (2) (whichever may be applicable) of section 1611(a)".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall become effective April 1, 1988.

SEC. 9106. EXCEPTION FROM SSI RETROSPECTIVE ACCOUNTING FOR AFDC AND CERTAIN OTHER ASSISTANCE PAYMENTS.

(a) IN GENERAL.—Section 1611(c) of the Social Security Act is amended—

(1) by striking "paragraphs (2), (3), and (4)" in paragraph (1) and inserting "paragraphs (2), (3), (4), and (5)";

(2) by redesignating paragraphs (5) and (6) as paragraphs (6) and (7), respectively; and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) Notwithstanding paragraphs (1) and (2), any income which is paid to or on behalf of an individual in any month pursuant to (A) a State plan approved under part A of title IV of this Act (relating to aid to families with dependent children), (B) section 472 of this Act (relating to foster care assistance), (C) section 412(e) of the Immigration and Nationality Act (relating to assistance for refugees), (D) section 501(a) of Public Law 96-422 (relating to assistance for Cuban and Haitian entrants), or (E) the Act of November 2, 1921 (42 Stat. 208), as amended (relating to assistance furnished by the Bureau of Indian Affairs), shall be taken into account in determining the amount of the benefit under this title of such individual (and his eligible spouse, if any) only for that month, and shall not be taken into account in determining the amount of the benefit for any other month.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall become effective April 1, 1988.

SEC. 9107. TECHNICAL AMENDMENT RELATING TO 1986 AMENDMENT CONCERNING THE TREATMENT OF CERTAIN COUPLES IN MEDICAL INSTITUTIONS.

Effective November 10, 1986, section 1611(e)(5) of the Social Security Act is amended—

(1) by striking "sharing a room or comparable accommodation in a hospital, home, or facility" and inserting "living in the same hospital, home, or facility"; and

(2) by striking "shared such a room or accommodation" and inserting "lived in the same such hospital, home, or facility".

SEC. 9108. EXTENSION OF DEADLINE FOR DISABLED WIDOWS TO APPLY FOR MEDICAID PROTECTION UNDER 1984 AMENDMENTS.

Effective July 1, 1987, section 1634(b)(3) of the Social Security Act is amended by striking "during the 15-month period beginning with the month in which this subsection is enacted" and inserting "no later than July 1, 1988".

SEC. 9109. INCREASE IN SSI EMERGENCY ADVANCE PAYMENTS.

(a) IN GENERAL.—Section 1631(a)(4)(A) of the Social Security Act is amended by striking "a cash advance against such benefits in an amount not exceeding $100" and inserting "a cash advance against such benefits, including any federally-administered State supplementary payments, in an amount not exceeding the monthly amount that would be payable to an eligible individual with no other income for the first month of such presumptive eligibility".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall become effective on the date of the enactment of this Act.

SEC. 9110. MODIFICATION OF INTERIM ASSISTANCE REIMBURSEMENT PROGRAM.

(a) IN GENERAL.—The first sentence of section 1631(g)(2) of the Social Security Act is amended by striking "at the time the Secretary makes the first payment of benefits" and inserting "at the time the Secretary makes the first payment of benefits with respect to the period described in clause (A) or (B) of paragraph (3)".

(b) DEFINITION OF INTERIM ASSISTANCE.—Section 1631(g)(3) of such Act is amended—

(1) by inserting "(A)" after "basic needs"; and

(2) by inserting before the period at the end the following: ", or (B) during the period beginning with the first month for which the individual's benefits (as defined in paragraph (2)) have been terminated or suspended if the individual was subsequently found to have been eligible for such benefits".

(c) EFFECTIVE DATE.—The amendments made by this section shall become effective with the 13th month following the month in which this Act is enacted, or, if sooner, with the first month for which the Secretary of Health and Human Services determines that it is administratively feasible.

SEC. 9111. SPECIAL NOTICE TO BLIND RECIPIENTS.

(a) IN GENERAL.—(1) Section 1631 of the Social Security Act is amended by adding at the end the following new subsection:

"Special Notice to Blind Individuals with Respect to Hearings and Other Official Actions

"(l)(1) In any case where an individual who is applying for or receiving benefits under this title on the basis of blindness is entitled (under subsection (c) or otherwise) to receive notice from the Secretary of any decision or determination made or other action taken or proposed to be taken with respect to his or her rights under this title, such individual shall at his or her election be entitled either (A) to receive a supplementary notice of such decision, determination, or action, by telephone, within 5 working days after the initial notice is mailed, (B) to receive the initial notice in the form of a certified letter, or (C) to receive notification by some alternative procedure established by the Secretary and agreed to by the individual.

"(2) The election under paragraph (1) may be made at any time; but an opportunity to make such an election shall in any event be given (A) to every individual who is an applicant for benefits under this title on the basis of blindness, at the time of his or her application, and (B) to every individual who is a recipient of such benefits on the basis of blindness, at the time of each redetermination of his or her eligibility. Such an election, once made by an individual, shall apply with respect to all notices of decisions, determinations, and actions which such individual may thereafter be entitled to receive under this title until such time as it is revoked or changed.".

(2) Not later than one year after the date on which the amendment made by paragraph (1) becomes effective, the Secretary of Health and Human Services shall provide every individual receiving benefits under title XVI of the Social Security Act on the basis of blindness an opportunity to make an election under section 1631(l)(1) of such Act (as added by such amendment).

(b) STUDY.—The Secretary of Health and Human Services shall study the desirability and feasibility of extending special or supplementary notices of the type provided to blind individuals by section 1631(l) of the Social Security Act (as added by subsection (a) of this section) to other individuals who may lack the ability to read and comprehend regular written notices, and shall report the results of such study to the Congress, along with such recommendations as may be appropriate, within 12 months after the date of the enactment of this Act.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall become effective July 1, 1988.

SEC. 9112. REHABILITATION SERVICES FOR BLIND SSI RECIPIENTS.

(a) IN GENERAL.—Section 1631(a)(6) of the Social Security Act is amended—

(1) by inserting "blindness (as determined under section 1614(a)(2)) or" before "disability (as determined under section 1614(a)(3))";

(2) by inserting "blindness or other" before "physical or mental impairment"; and

(3) by inserting "blindness and" before "disability benefit rolls" in subparagraph (B).

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall become effective April 1, 1988.

SEC. 9113. EXTENDING THE NUMBER OF MONTHS THAT AN INDIVIDUAL IN A PUBLIC EMERGENCY SHELTER CAN BE ELIGIBLE FOR SSI.

(a) IN GENERAL.—Section 1611(e)(1)(D) of the Social Security Act is amended by striking "three months in any 12-month period" and inserting "6 months in any 9-month period".

(b) EFFECTIVE DATE.—(1) The amendment made by subsection (a) shall become effective January 1, 1988.

(2) In the application of section 1611(e)(1)(D) of the Social Security Act on and after the effective date of such amendment, months before January 1988 in which a person was an eligible individual or eligible spouse by reason of such section shall not be taken into account.

SEC. 9114. EXCLUSION OF UNDERPAYMENTS FROM RESOURCES.

(a) IN GENERAL.—Section 1613(a)(7) of the Social Security Act is amended by inserting after "shall be limited to the first 6 months following the month in which such amount is received" the following: "(or to the first 9 months following such month with respect to any amount so received during the period beginning October 1, 1987, and ending September 30, 1989)".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall become effective January 1, 1988.

SEC. 9115. CONTINUATION OF FULL BENEFIT STANDARD FOR INDIVIDUALS TEMPORARILY INSTITUTIONALIZED.

(a) IN GENERAL.—Section 1611(e)(1) of the Social Security Act is amended—

(1) in subparagraph (A), by striking "and (E)" and inserting "(E), and (G)";

(2) in subparagraph (B), by inserting "(subject to subparagraph (G))' ' after "throughout any month"; and

(3) by adding at the end the following new subparagraphs:

"(G) A person may be an eligible individual or eligible spouse for purposes of this title, and subparagraphs (A) and (B) shall not apply, with respect to any particular month throughout which he or she is an inmate of a public institution the primary purpose of which is the provision of medical or psychiatric care, or which is a hospital, extended care facility, nursing home, or intermediate care facility receiving payments (with respect to such individual or

spouse) under a State plan approved under title XIX, if it is determined in accordance with subparagraph (H) that—

"(i) such person's stay in that institution or facility (or in that institution or facility and one or more other such institutions or facilities during a continuous period of institutionalization) is likely (as certified by a physician) not to exceed 3 months, and the particular month involved is one of the first 3 months throughout which such person is in such an institution or facility during a continuous period of institutionalization; and

"(ii) such person needs to continue to maintain and provide for the expenses of the home or living arrangement to which he or she may return upon leaving the institution or facility.

The benefit of any person under this title (including State supplementation if any) for each month to which this subparagraph applies shall be payable, without interruption of benefit payments and on the date the benefit involved is regularly due, at the rate that was applicable to such person in the month prior to the first month throughout which he or she is in the institution or facility.

"(H) The Secretary shall establish procedures for the determinations required by clauses (i) and (ii) of subparagraph (G), and may enter into agreements for making such determinations (or for providing information or assistance in connection with the making of such determinations) with appropriate State and local public and private agencies and organizations. Such procedures and agreements shall include the provision of appropriate assistance to individuals who, because of their physical or mental condition, are limited in their ability to furnish the information needed in connection with the making of such determinations.".

(b) CONFORMING AMENDMENT.—Section 1902(l) of such Act is amended by striking "section 1611(e)(1)(E)" and inserting "subparagraph (E) or (G) of section 1611(e)(1)".

(c) EFFECTIVE DATE.—The amendments made by this section shall become effective July 1, 1988.

SEC. 9116. RETENTION OF MEDICAID WHEN SSI BENEFITS ARE LOST UPON ENTITLEMENT TO EARLY WIDOW'S OR WIDOWER'S INSURANCE BENEFITS.

(a) IN GENERAL.—Section 1634 of the Social Security Act is amended by adding at the end the following new subsection:

"(d) If any person—

"(1) applies for and obtains benefits under subsection (e) or (f) of section 202 (or under any other subsection of section 202 if such person is also eligible for benefits under such subsection (e) or (f)) as required by section 1611(e)(2), being then at least 60 years of age but not entitled to hospital insurance benefits under part A of title XVIII, and

"(2) is determined to be ineligible (by reason of the receipt of such benefits under section 202) for supplemental security income benefits under this title or for State supplementary payments of the type described in section 1616(a),

such person shall nevertheless be deemed to be a recipient of supplemental security income benefits under this title for purposes of title XIX, so long as he or she (A) would be eligible for such supplemental security income benefits, or such State supplementary payments,

in the absence of such benefits under section 202, and (B) is not entitled to hospital insurance benefits under part A of title XVIII.".

(b) NOTICE.—The Secretary of Health and Human Services, acting through the Social Security Administration, shall (within 3 months after the date of the enactment of this Act) issue a notice to all individuals who will have attained age 60 but not age 65 as of April 1, 1988, and who received supplemental security income benefits under title XVI of the Social Security Act prior to attaining age 60 but lost those benefits by reason of the receipt of widow's or widower's insurance benefits (or other benefits as described in section 1634(d)(1) of that Act as added by subsection (a) of this section) under title II of that Act. Each such notice shall set forth and explain the provisions of section 1634(d) of the Social Security Act (as so added), and shall inform the individual that he or she should contact the Secretary or the appropriate State agency concerning his or her possible eligibility for medical assistance benefits under such title XIX.

(c) STATE DETERMINATIONS.—Any determination required under section 1634(d) of the Social Security Act with respect to whether an individual would be eligible for benefits under title XVI of such Act (or State supplementary payments) in the absence of benefits under section 202 shall be made by the appropriate State agency.

(d) CONFORMING AMENDMENTS.—Section 1922(a)(2) of the Social Security Act is amended—

(1) by striking "1634 (b)" in subparagraph (B) and inserting "1634 (b) and (c)"; and

(2) by adding at the end the following new subparagraph:

"(C) Section 1634(d) of this Act (relating to individuals who lose eligibility for SSI benefits due to entitlement to early widow's or widower's insurance benefits under section 202 (e) or (f) of this Act).".

(e) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to any individual without regard to whether the determination of his or her ineligibility for supplemental security income benefits by reason of the receipt of benefits under section 202 of the Social Security (as described in section 1634(d)(2) of such Act) occurred before, on, or after the date of the enactment of this Act; but no individual shall be eligible for assistance under title XIX of such Act by reason of such amendments for any period before July 1, 1988.

SEC. 9117. DEMONSTRATION PROGRAM TO ASSIST HOMELESS INDIVIDUALS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") is authorized to make grants to States for projects designed to demonstrate and test the feasibility of special procedures and services to ensure that homeless individuals are provided SSI and other benefits under the Social Security Act to which they are entitled and receive assistance in using such benefits to obtain permanent housing, food, and health care. Each project approved under this section shall meet such conditions and requirements, consistent with this section, as the Secretary shall prescribe.

(b) SCOPE OF PROJECTS.—Projects for which grants are made under this section shall include, more specifically, procedures and

services to overcome barriers which prevent homeless individuals (particularly the chronically mentally ill) from receiving and appropriately using benefits, including—

(1) the creation of cooperative approaches between the Social Security Administration, State and local governments, shelters for the homeless, and other providers of services to the homeless;

(2) the establishment, where appropriate, of multi-agency SSI Outreach Teams (as described in subsection (c)), to facilitate communication between the agencies and staff involved in taking and processing claims for SSI and other benefits by the homeless who use shelters;

(3) special efforts to identify homeless individuals who are potentially eligible for SSI or other benefits under the Social Security Act;

(4) the provision of special assistance to the homeless in applying for benefits, including assistance in obtaining and developing evidence of disability and supporting documentation for nondisability-related eligibility requirements;

(5) the provision of special training and assistance to public and private agency staff, including shelter employees, on disability eligibility procedures and evidentiary requirements;

(6) the provision of ongoing assistance to formerly homeless individuals to ensure their responding to information requests related to periodic redeterminations of eligibility for SSI and other benefits;

(7) the provision of assistance in ensuring appropriate use of benefit funds for the purpose of enabling homeless individuals to obtain permanent housing, nutrition, and physical and mental health care, including the use, where appropriate, of the disabled individual's representative payee for case management services; and

(8) such other procedures and services as the Secretary may approve.

(c) SSI OUTREACH TEAM PROJECTS.—(1) If a State applies for funds under this section for the purpose of establishing a multi-agency SSI Outreach Team, the membership and functions of such team shall be as follows (except as provided in paragraph (2)):

(A) The membership of the Team shall include a social services case worker (or case workers, if necessary); a consultative medical examiner who is qualified to provide consultative examinations for the Disability Determination Service of the State; a disability examiner, from the State Disability Determination Service; and a claims representative from an office of the Social Security Administration.

(B) The Team shall have designated members responsible for—

(i) identification of homeless individuals who are potentially eligible for SSI or other benefits under the Social Security Act;

(ii) ensuring that such individuals understand their rights under the programs;

(iii) assisting such individuals in applying for benefits, including assistance in obtaining and developing evidence

and supporting documentation relating to disability- and nondisability-related eligibility requirements;

(iv) arranging transportation and accompanying applicants to necessary examinations, if needed; and

(v) providing for the tracking and monitoring of all claims for benefits by individuals under the project.

(2) If the Secretary determines that an application by a State for an SSI Outreach Team Project under this section which proposes a membership and functions for such Team different from those prescribed in paragraph (1) but which is expected to be as effective, the Secretary may waive the requirements of such paragraph.

(d) INFORMATION AND REPORTS; EVALUATION.—(1) Each State having an approved SSI Outreach Team Project shall periodically submit to the Secretary such information (with respect to the project) as may be necessary to enable the Secretary to evaluate such project in particular and the demonstration program under this section in general.

(2)(A) The Secretary shall from time to time (but not less often than annually) submit to the Congress a full and complete report on the program under this section, together with a detailed evaluation of such program and of the projects thereunder along with such recommendations as may be deemed appropriate. Such evaluation and such recommendations shall be designed to serve as a basis for determining whether (and to what extent) the activities and procedures included in the demonstration program under this section should be continued, expanded, or modified, or converted (with or without changes) into a regular feature of permanent law.

(B) The criteria used by the Secretary in evaluating the program and the projects thereunder shall not be limited to those which would normally be used in evaluating programs and activities of the kind involved, but shall fully take into account the special circumstances of the homeless and their need for personalized attention and follow-through assistance, and shall emphasize the extent to which the procedures and assistance made available to applicants under such projects are recognizing those circumstances and meeting that need.

(e) AUTHORIZATION OF APPROPRIATIONS.—To carry out this section, there are authorized to be appropriated to the Secretary—

(A) the sum of $1,250,000 for the fiscal year 1988;

(B) the sum of $2,500,000 for the fiscal year 1989; and

(C) such sums as may be necessary for each fiscal year thereafter.

SEC. 9118. ASSISTANCE TO HOMELESS AFDC FAMILIES.

The Secretary of Health and Human Services may not take any action, prior to October 1, 1988, that would have the effect of implementing in whole or in part the proposed regulation published in the Federal Register on December 14, 1987, with respect to emergency assistance and the need for and amount of assistance under the program of aid to families with dependent children, or that would change current policy with respect to any of the matters addressed in such proposed regulation.

SEC. 9119. INCREASE IN PERSONAL NEEDS ALLOWANCE FOR SSI RECIPIENTS.

(a) INCREASE IN STANDARD.—Section 1611(e)(1)(B) of the Social Security Act is amended—

(1) by striking "$300 per year" in clauses (i) and (ii)(I) and inserting "$360 per year"; and

(2) by striking "$600 per year" in clause (iii) and inserting "$720 per year".

(b) MANDATORY PASS-THROUGH OF INCREASED PERSONAL NEEDS ALLOWANCE.—Section 1618 of such Act is amended by adding at the end the following new subsection:

"(g) In order for any State which makes supplementary payments of the type described in section 1616(a) (including payments pursuant to an agreement entered into under section 212(a) of Public Law 93-66) to recipients of benefits determined under section 1611(e)(1)(B), on or after October 1, 1987, to be eligible for payments pursuant to title XIX with respect to any calendar quarter which begins—

"(1) after October 1, 1987, or, if later

"(2) after the calendar quarter in which it first makes such supplementary payments to recipients of benefits so determined, such State must have in effect an agreement with the Secretary whereby the State will—

"(3) continue to make such supplementary payments to recipients of benefits so determined, and

"(4) maintain such supplementary payments to recipients of benefits so determined at levels which assure (with respect to any particular month beginning with the month in which this subsection is first effective) that—

"(A) the combined level of such supplementary payments and the amounts payable to or on behalf of such recipients under section 1611(e)(1)(B) for that particular month,

is not less than—

"(B) the combined level of such supplementary payments and the amounts payable to or on behalf of such recipients under section 1611(e)(1)(B) for October 1987 (or, if no such supplementary payments were made for that month, the combined level for the first subsequent month for which such payments were made), increased—

"(i) in a case to which clause (i) of such section 1611(e)(1)(B) applies or (with respect to the individual or spouse who is in the hospital, home, or facility involved) to which clause (ii) of such section applies, by $5, and

"(ii) in a case to which clause (iii) of such section 1611(e)(1)(B) applies, by $10.".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall become effective July 1, 1988.

SEC. 9120. EXCLUSION OF DEATH BENEFITS TO THE EXTENT SPENT ON LAST ILLNESS AND BURIAL.

(a) IN GENERAL.—Subparagraphs (D) and (E) of section 1612(a)(2) of the Social Security Act are amended to read as follows:

"(D) payments to the individual occasioned by the death of another person, to the extent that the total of such pay-

ments exceeds the amount expended by such individual for purposes of the deceased person's last illness and burial;

"(E) support and alimony payments, and (subject to the provisions of subparagraph (D) excluding certain amounts expended for purposes of a last illness and burial) gifts (cash or otherwise) and inheritances; and".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall become effective April 1, 1988.

SEC. 9121. DEMONSTRATION OF FAMILY INDEPENDENCE PROGRAM.

(a) IN GENERAL.—Upon application of the State of Washington and approval by the Secretary of Health and Human Services, the State of Washington (in this section referred to as the "State") may conduct a demonstration project in accordance with this section for the purpose of testing whether the operation of its Family Independence Program enacted in May 1987 (in this section referred to as the "Program"), as an alternative to the AFDC program under title IV of the Social Security Act, would more effectively break the cycle of poverty and provide families with opportunities for economic independence and strengthened family functioning.

(b) NATURE OF PROJECT.—Under the demonstration project conducted under this section—

(1) every individual eligible for aid under the State plan approved under section 402(a) of the Social Security Act shall be eligible to enroll in the Program, which shall operate simultaneously with the AFDC program so long as there are individuals who qualify for the latter;

(2) cash assistance shall be furnished in a timely manner to all eligible individuals under the Program (and the State may not make expenditures for services under the Program until it has paid all necessary cash assistance), with no family receiving less in cash benefits than it would have received under the AFDC program;

(3) individuals may be required to register, undergo assessment, and participate in work, education, or training under the Program, except that—

(A) work or training may not be required in the case of—

(i) a single parent of a child under six months of age, or more than one parent of such a child in a two-parent family,

(ii) a single parent with a child of any age who has received assistance for less than six months,

(iii) a single parent with a child under three years of age who has received assistance for less than three years,

(iv) an individual under 16 years of age or over 64 years of age,

(v) an individual who is incapacitated, temporarily ill, or needed at home to care for an impaired person, or

(vi) an individual who has not yet been individually notified in writing of such requirement or of the expiration of his or her exempt status under this subparagraph;

(B) participation in work or training shall in any case be voluntary during the first two years of the Program, and may thereafter be made mandatory only in counties where more than 50 percent of the enrollees can be placed in employment within three months after they are job ready;

(C) in no case shall the work and training aspect of the Program be mandated in any county where the unemployment level is at least twice the State average; and

(D) mandated work shall not include work in any position created by a reduction in the work force, a bona fide labor dispute, the decertification of a bargaining unit, or a new job classification which subverts the intention of the Program;

(4) there shall be no change in existing State law which would eliminate guaranteed benefits or reduce the rights of applicants or enrollees; and

(5) the Program shall include due process guarantees and procedures no less than those which are available to participants in the AFDC program under Federal law and regulation and under State law.

(c) WAIVERS.—The Secretary shall (with respect to the project under this section) waive compliance with any requirements contained in title IV of the Social Security Act which (if applied) would prevent the State from carrying out the project or effectively achieving its purpose, or with the requirements of sections 1902(a)(1), 1902(e)(1), and 1916 of that Act (but only to the extent necessary to enable the State to carry out the program as enacted by the State in April 1987).

(d) FUNDING.—

(1) The Secretary, under section 403(b) or 1903(d) of the Social Security Act, shall reimburse the State for its expenditures under the Program—

(A) at a rate equal to the Federal matching rate applicable to the State under section 403(a)(1) (or 1118) of the Social Security Act, for cash assistance, medical assistance, and child care provided to enrollees;

(B) at a rate equal to the applicable Federal matching rate under section 403(a)(3) of such Act, for administrative expenses; and

(C) at the rate of 75 percent for an evaluation plan approved by the Secretary.

(2) As a condition of approval of the project under this section, the State must provide assurances satisfactory to the Secretary that the total amount of Federal reimbursement over the period of the project will not exceed the anticipated Federal reimbursements (over that period) under the AFDC and Medicaid programs; but this paragraph shall not prevent the State from claiming reimbursement for additional persons who would qualify for assistance under the AFDC program, for costs attributable to increases in the State's payment standard, or for any other federally-matched benefits or services.

(e) EVALUATION.—The State must satisfy the Secretary that the program will be evaluated using a reasonable methodology.

(f) DURATION OF PROJECT.—

(1) The project under this section shall begin on the date on which the first individual is enrolled in the Program and (subject to paragraph (2)) shall end five years after that date.

(2) The project may be terminated at any time, on six months' written notice, by the State or (upon a finding that the State has materially failed to comply with this section) by the Secretary.

SEC. 9122. CHILD SUPPORT DEMONSTRATION PROGRAM IN NEW YORK STATE.

(a) IN GENERAL.—Upon application by the State of New York and approval by the Secretary of Health and Human Services (in this section referred to as the "Secretary"), the State of New York (in this section referred to as the "State") may conduct a demonstration program in accordance with this section for the purpose of testing a State program as an alternative to the program of Aid to Families with Dependent Children under title IV of the Social Security Act.

(b) NATURE OF PROGRAM.—Under the demonstration program conducted under this section—

(1) all custodial parents of dependent children who are eligible for supplements under the State plan approved under section 402(a) of the Social Security Act (and such other types or classes of such parents as the State may specify) may elect to receive benefits under the State's Child Support Supplement Program in lieu of supplements under such plan; and

(2) the Federal Government will pay to the State with respect to families receiving benefits under the State's Child Support Supplement Program the same amounts as would have been payable with respect to such families under sections 403 and 1903 of the Social Security Act as if the families were receiving aid and medical assistance under the State plans in effect with respect to such sections.

(c) WAIVERS.—The Secretary shall (with respect to the program under this section) waive compliance with any requirements contained in title IV of the Social Security Act which (if applied) would prevent the State from carrying out the program or effectively achieving its purpose.

(d) CONDITIONS OF APPROVAL.—As a condition of approval of the program under this section, the State shall—

(1) provide assurances satisfactory to the Secretary that the State—

(A) will continue to make assistance available to all eligible children in the State who are in need of financial support, and

(B) will continue to operate an effective child support enforcement program;

(2) agree—

(A) to have the program evaluated, and

(B) to report interim findings to the Secretary at such times as the Secretary shall provide; and

(3) satisfy the Secretary that the program will be evaluated using a reasonable methodology that can determine whether changes in work behavior and changes in earnings are attributable to participation in the program.

(e) APPLICATION PROCESS.—In order to participate in the program under this section, the State must submit an application under this section not later than two years after the date of enactment of this Act. The Secretary shall approve or disapprove the application of the State not later than 90 days after the date of its submission. If the application is disapproved, the Secretary shall provide to the State a statement of the reasons for such disapproval, of the changes needed to obtain approval, and of the date by which the State may resubmit the application.

(f) EFFECTIVE DATE.—The program under this section shall commence not later than the first day of the third calendar quarter beginning on or after the date on which the application of the State is approved in accordance with subsection (e).

(g) DURATION OF PROGRAM.—

(1) Except as provided in paragraph (2), if the Secretary approves the application of the State, the demonstration program under this section shall be conducted for a period not to exceed five years.

(2)(A) The Governor of the State may before the end of the period described in paragraph (1) terminate the demonstration program under this section if the Governor finds that the program is not successful in testing the State's Child Support Supplement Program as an alternative to the program under title IV of the Social Security Act. The Governor shall notify the Secretary of the decision to terminate the program not less than three months prior to the date of such termination.

(B) The Secretary may terminate the program before the end of such period if the Secretary finds that the program is not in compliance with the terms of the application. The Secretary shall notify the Governor of the decision to terminate the program not less than three months prior to the date of such termination.

SEC. 9123. TECHNICAL CORRECTION.

The subsection of section 1631 of the Social Security Act which was added as subsection (j) by section 11006 of the Anti-Drug Abuse Act of 1986 is redesignated as subsection (m) and is moved to the end of such section 1631 so that it appears immediately after subsection (l) thereof (as added by section 9111(a) of this Act); and the heading of such subsection is amended to read as follows:

"Pre-Release Procedures for Institutionalized Persons".

PART 2—SOCIAL SERVICES, CHILD WELFARE SERVICES, AND OTHER PROVISIONS RELATING TO CHILDREN

SEC. 9131. PERMANENT EXTENSION OF AUTHORITY FOR VOLUNTARY FOSTER CARE PLACEMENTS.

(a) IN GENERAL.—Section 102 of the Adoption Assistance and Child Welfare Act of 1980 is amended—

(1) in subsection (a)(1) (in the matter preceding subparagraph (A)), by striking "and before October 1, 1987,";

(2) in subsection (c), by striking all that follows "September 30, 1979" and inserting a period; and

(3) in subsection (e), by striking "with respect to which the amendments made by this section are in effect".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall become effective October 1, 1987.

SEC. 9132. 2-YEAR EXTENSION OF FOSTER CARE CEILING AND OF AUTHORITY TO TRANSFER FOSTER CARE FUNDS TO CHILD WELFARE SERVICES.

(a) IN GENERAL.—Section 474 of the Social Security Act is amended—

(1) in paragraphs (1), (2)(A)(iii), (2)(B), (4)(B), and (5)(A)(ii) of subsection (b), by striking "through 1987" and inserting "through 1989";

(2) in paragraph (5)(A) of subsection (b) (in the matter preceding clause (i)), by striking "October 1, 1987" and inserting "October 1, 1989"; and

(3) in paragraphs (1) and (2) of subsection (c), by striking "through 1987" and inserting "through 1989".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall become effective October 1, 1987.

SEC. 9133. MOTHER/INFANT FOSTER CARE.

(a) IN GENERAL.—Section 475(4) of the Social Security Act is amended—

(1) by inserting "(A)" after "(4)"; and

(2) by adding at the end the following new subparagraph:

"(B) In cases where—

"(i) a child placed in a foster family home or child-care institution is the parent of a son or daughter who is in the same home or institution, and

"(ii) payments described in subparagraph (A) are being made under this part with respect to such child,

the foster care maintenance payments made with respect to such child as otherwise determined under subparagraph (A) shall also include such amounts as may be necessary to cover the cost of the items described in that subparagraph with respect to such son or daughter.".

(b) CONFORMING AMENDMENTS RELATING TO ELIGIBILITY UNDER OTHER PROGRAMS.—(1) Section 402(a)(24) of such Act is amended by striking "if an individual is receiving benefits under title XVI, then, for the period for which such benefits are received," and inserting the following: "if an individual is receiving benefits under title XVI or his costs in a foster family home or child-care institution are covered by the foster care maintenance payments being made to his or her minor parent as provided in section 475(4)(B), then, for the period for which such benefits are received or such costs are so covered,".

(2) Section 472(h) of such Act is amended by adding at the end the following new sentence: "For purposes of the preceding sentence, a child whose costs in a foster family home or child-care institution are covered by the foster care maintenance payments being made with respect to his or her minor parent, as provided in section 475(4)(B), shall be considered a child with respect to whom foster care maintenance payments are made under this section.".

(3)(A) Section 473(a)(2)(A) of such Act is amended—

(i) by striking "or" at the end of clause (i);

(ii) by adding "or" at the end of clause (ii); and

(iii) by adding after clause (ii) the following new clause:

"(iii) is a child whose costs in a foster family home or child-care institution are covered by the foster care maintenance payments being made with respect to his or her minor parent as provided in section 475(4)(B),".

(B) Section 473(a)(2)(B)(iii) of such Act is amended by inserting "or (A)(iii)" after "(A)(ii)".

(4) Section 473(b) of such Act is amended by adding at the end the following new sentence: "For purposes of the preceding sentence, a child whose costs in a foster family home or child-care institution are covered by the foster care maintenance payments being made with respect to his or her minor parent, as provided in section 475(4)(B), shall be considered a child with respect to whom foster care maintenance payments are being made under section 472.".

(c) EFFECTIVE DATE.—The amendments made by this section shall become effective April 1, 1988.

SEC. 9134. INCREASED FUNDING FOR SOCIAL SERVICES BLOCK GRANTS.

(a) INCREASE IN FUNDING.—Section 2003(c) of the Social Security Act is amended—

(A) by striking "and" at the end of paragraph (2);

(B) in paragraph (3), by striking "year" the first place it appears and all that follows through the period and inserting "years 1984, 1985, 1986, and 1987, and for each succeeding fiscal year other than the fiscal year 1988; and"; and

(C) by adding at the end the following new paragraph:

"(4) $2,750,000,000 for the fiscal year 1988.".

(b) REQUIREMENT THAT ADDITIONAL FUNDS SUPPLEMENT AND NOT SUPPLANT FUNDS AVAILABLE FROM OTHER SOURCES.—The additional $50,000,000 made available to the States for the fiscal year 1988 pursuant to the amendments made by subsection (a) shall—

(A) be used only for the purpose of providing additional services under title XX of the Social Security Act; and

(B) be expended only to supplement the level of any funds that would, in the absence of the additional funds appropriated pursuant to such amendments, be available from other sources (including any amounts available under title XX of the Social Security Act without regard to such amendments) for services in accordance with such title, and shall in no case supplant such funds from other sources or reduce the level thereof.

SEC. 9135. EXTENSION OF SOCIAL SERVICES BLOCK GRANT AND CHILD WELFARE SERVICES PROGRAMS TO AMERICAN SAMOA.

(a) SOCIAL SERVICES BLOCK GRANT PROGRAM.—(1) Section 1101(a)(1) of the Social Security Act is amended by inserting "American Samoa," after "Guam," in the last sentence.

(2)(A) Section 2003(a) of such Act is amended by adding at the end the following new sentence: "The allotment for fiscal year 1989 and each succeeding fiscal year to American Samoa shall be an amount which bears the same ratio to the amount allotted to the Northern Mariana Islands for that fiscal year as the population of American Samoa bears to the population of the Northern Mariana Islands de-

termined on the basis of the most recent data available at the time such allotment is determined.".

(B) Section 2003(b) of such Act is amended by inserting "American Samoa," after "the Virgin Islands," each place it appears.

(b) CHILD WELFARE SERVICES PROGRAM.—(1) Section 1101(a)(1) of such Act is amended by adding at the end thereof the following new sentence: "Such term when used in part B of title IV also includes American Samoa.".

(2) Section 421(b) of such Act is amended by striking "and Guam" and inserting "Guam, and American Samoa".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to fiscal years beginning on or after October 1, 1988.

SEC. 9136. NATIONAL COMMISSION ON CHILDREN.

Part A of title XI of the Social Security Act is amended by adding at the end the following new section:

"NATIONAL COMMISSION ON CHILDREN

"SEC. 1139. (a)(1) There is hereby established a commission to be known as the National Commission on Children (in this section referred to as the 'Commission').

"(b)(1) The Commission shall consist of—

"(A) 12 members to be appointed by the President,

"(B) 12 members to be appointed by the Speaker of the House of Representatives, and

"(C) 12 members to be appointed by the President pro tempore of the Senate.

"(2) The President, the Speaker, and the President pro tempore shall each appoint as members of the Commission—

"(A) 4 individuals who—

"(i) are representatives of organizations providing services to children,

"(ii) are involved in activities on behalf of children, or

"(iii) have engaged in academic research with respect to the problems and needs of children,

"(B) 4 individuals who are elected or appointed public officials (at the Federal, State, or local level) involved in issues and programs relating to children, and

"(C) 4 individuals who are parents or representatives of parents or parents' organizations.

"(3) The appointments made pursuant to subparagraphs (B) and (C) of paragraph (1) shall be made in consultation with the chairmen of committees of the House of Representatives and the Senate, respectively, having jurisdiction over relevant Federal programs.

"(c)(1) It shall be the duty and function of the Commission to serve as a forum on behalf of the children of the Nation and to conduct the studies and issue the report required by subsection (d).

"(2) The Commission (and any committees that it may form) shall conduct public hearings in different geographic areas of the country, both urban and rural, in order to receive the views of a broad spectrum of the public on the status of the Nation's children and on ways to safeguard and enhance the physical, mental, and emotional well-being of all of the children of the Nation, including those with

physical or mental disabilities, and others whose circumstances deny them a full share of the opportunities that parents of the Nation may rightfully expect for their children.

"(3) The Commission shall receive testimony from individuals, and from representatives of public and private organizations and institutions with an interest in the welfare of children, including educators, health care professionals, religious leaders, providers of social services, representatives of organizations with children as members, elected and appointed public officials, and from parents and children speaking in their own behalf.

"(d) The Commission shall submit to the President, and to the Committees on Finance and Labor and Human Resources of the Senate and the Committees on Ways and Means, Education and Labor, and Energy and Commerce of the House of Representatives, an interim report no later than September 30, 1988, and a final report no later than March 31, 1989, setting forth recommendations with respect to the following subjects:

"(1) Questions relating to the health of children that the Commission shall address include—

"(A) how to reduce infant mortality,

"(B) how to reduce the number of low-birth-weight babies,

"(C) how to reduce the number of children with chronic illnesses and disabilities,

"(D) how to improve the nutrition of children,

"(E) how to promote the physical fitness of children,

"(F) how to ensure that pregnant women receive adequate prenatal care,

"(G) how to ensure that all children have access to both preventive and acute care health services, and

"(H) how to improve the quality and availability of health care for children.

"(2) Questions relating to social and support services for children and their parents that the Commission shall address include—

"(A) how to prevent and treat child neglect and abuse,

"(B) how to provide help to parents who seek assistance in meeting the problems of their children,

"(C) how to provide counseling services for children,

"(D) how to strengthen the family unit,

"(E) how children can be assured of adequate care while their parents are working or participating in education or training programs,

"(F) how to improve foster care and adoption services,

"(G) how to reduce drug and alcohol abuse by children and youths, and

"(H) how to reduce the incidence of teenage pregnancy.

"(3) Questions relating to education that the Commission shall address include—

"(A) how to encourage academic excellence for all children at all levels of education,

"(B) how to use preschool experiences to enhance educational achievement,

"(C) how to improve the qualifications of teachers,

"(D) how schools can better prepare the Nation's youth to compete in the labor market,

"(E) how parents and schools can work together to help children achieve success at each step of the academic ladder,

"(F) how to encourage teenagers to complete high school and remain in school to fulfill their academic potential,

"(G) how to address the problems of drug and alcohol abuse by young people,

"(H) how schools might lend support to efforts aimed at reducing the incidence of teenage pregnancy, and

"(I) how schools might better meet the special needs of children who have physical or mental handicaps.

"(4) Questions relating to income security that the Commission shall address include—

"(A) how to reduce poverty among children,

"(B) how to ensure that parents support their children to the fullest extent possible through improved child support collection services, including services on behalf of children whose parents are unmarried, and

"(C) how to ensure that cash assistance to needy children is adequate.

"(5) Questions relating to tax policy that the Commission shall address include—

"(A) how to assure the equitable tax treatment of families with children,

"(B) the effect of existing tax provisions, including the dependent care tax credit, the earned income tax credit, and the targeted jobs tax credit, on children living in poverty,

"(C) whether the dependent care tax credit should be refundable and the effect of such a policy,

"(D) whether the earned income tax credit should be adjusted for family size and the effect of such a policy, and

"(E) whether there are other tax-related policies which would reduce poverty among children.

"(6) In addition to addressing the questions specified in paragraphs (1) through (5), the Commission shall—

"(A) seek to identify ways in which public and private organizations and institutions can work together at the community level to identify deficiencies in existing services for families and children and to develop recommendations to ensure that the needs of families and children are met, using all available resources, in a coordinated and comprehensive manner, and

"(B) assess the existing capacities of agencies to collect and analyze data on the status of children and on relevant programs, identify gaps in the data collection system, and recommend ways to improve the collection of data and the coordination among agencies in the collection and utilization of data.

The reports required by this subsection shall be based upon the testimony received in the hearings conducted pursuant to subsection (c), and upon other data and findings developed by the Commission.

"(e)(1)(A) Members of the Commission shall first be appointed not later than 60 days after the date of the enactment of this section, for terms ending on March 31, 1989.

"(B) A vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as the vacant position was first filled.

"(2) The Commission shall elect one of its members to serve as Chairman of the Commission. The Chairman shall be a nonvoting member of the Commission.

"(3) A majority of the members of the Commission shall constitute a quorum for the transaction of business.

"(4)(A) The Commission shall meet at the call of the Chairman, or at the call of a majority of the members of the Commission.

"(B) The Commission shall meet not less than 4 times during the period beginning with the date of the enactment of this section and ending with March 31, 1989.

"(5) Decisions of the Commission shall be according to the vote of a simple majority of those present and voting at a properly called meeting.

"(6) Members of the Commission shall serve without compensation, but shall be reimbursed for travel, subsistence, and other necessary expenses incurred in the performance of their duties as members of the Commission.

"(f)(1) The Commission shall appoint an Executive Director of the Commission who shall be compensated at a rate fixed by the Commission, but which shall not exceed the rate established for level V of the Executive Schedule under title 5, United States Code.

"(2) In addition to the Executive Director, the Commission may appoint and fix the compensation of such personnel as it deems advisable, in accordance with the provisions of title 5, United States Code, governing appointments to the competitive service, and the provisions of chapter 51 and subchapter III of chapter 53 of such title, relating to classification and General Schedule pay rates.

"(g) In carrying out its duties, the Commission, or any duly organized committee thereof, is authorized to hold such hearings, sit and act at such times and places, and take such testimony, with respect to matters for which it has a responsibility under this section, as the Commission or committee may deem advisable.

"(h)(1) The Commission may secure directly from any department or agency of the United States such data and information as may be necessary to carry out its responsibilities.

"(2) Upon request of the Commission, any such department or agency shall furnish any such data or information.

"(i) The General Services Administration shall provide to the Commission, on a reimbursable basis, such administrative support services as the Commission may request.

"(j) There are authorized to be appropriated such sums as may be necessary to carry out this section.".

SEC. 9137. BOARDER BABIES DEMONSTRATION PROJECT.

Section 426 of the Social Security Act is amended—

(1) by redesignating subsection (b) as subsection (c); and

(2) by inserting immediately after subsection (a) the following new subsection:

"(b)(1) There are authorized to be appropriated $4,000,000 for each of the fiscal years 1988, 1989, and 1990 for grants by the Secretary to public or private nonprofit entities submitting applications under this subsection for the purpose of conducting demonstration projects under this subsection to develop alternative care arrangements for infants who do not have health conditions that require hospitalization and who would otherwise remain in inappropriate hospital settings.

"(2) The demonstration projects conducted under this section may include—

"(A) multidisciplinary projects designed to prevent the inappropriate hospitalization of infants and to allow infants described in paragraph (1) to remain with or return to a parent in a residential setting, where appropriate care for the infant and suitable treatment for the parent (including treatment for drug or alcohol addiction) may be assured, with the goal (where possible) of rehabilitating the parent and eliminating the need for such care for the infant;

"(B) multidisciplinary projects that assure appropriate, individualized care for such infants in a foster home or other non-medical residential setting in cases where such infant does not require hospitalization and would otherwise remain in inappropriate hospital settings, including projects to demonstrate methods to recruit, train, and retain foster care families; and

"(C) such other projects as the Secretary determines will best serve the interests of such infants and will serve as models for projects that agencies or organizations in other communities may wish to develop.

"(3) In the case of any project which includes the use of funds authorized under this subsection for the care of infants in foster homes or other non-medical residential settings away from their parents, there shall be developed for each such infant a case plan of the type described in section 475(1) (to the extent that such infant is not otherwise covered by such a plan), and each such project shall include a case review system of the type described in section 475(5) (covering each such infant who is not otherwise subject to such a system).

"(4) In evaluating applications from entities proposing to conduct demonstration projects under this subsection, the Secretary shall give priority to those projects that serve areas most in need of alternative care arrangements for infants described in paragraph (1).

"(5) No project may be funded unless the application therefor contains assurances that it will—

"(A) provide for adequate evaluation;

"(B) provide for coordination with local governments;

"(C) provide for community education regarding the inappropriate hospitalization of infants;

"(D) use, to the extent practical, other available private, local, State, and Federal sources for the provision of direct services; and

"(E) meet such other criteria as the Secretary may prescribe.

"(6) Grants may be used to pay the costs of maintenance and of necessary medical and social services (to the extent that these costs

are not otherwise paid for under other titles of this Act), and for such other purposes as the Secretary may allow.

"(7) The Secretary shall provide training and technical assistance to grantees, as requested.".

SEC. 9138. STUDY OF INFANTS AND CHILDREN WITH AIDS IN FOSTER CARE.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall conduct (or arrange for) a survey to determine—

(1) the total number of infants and children in the United States who have been diagnosed as having acquired immune deficiency syndrome and who have been placed in foster care;

(2) the problems encountered by social service agencies in placing infants and children with such syndrome in foster care; and

(3) the potential increase (over the five-year period beginning on the date of the enactment of this Act) in the number of infants and children with such syndrome who will require foster care.

For purposes of this section, an infant or child with acquired immune deficiency syndrome includes an infant or child who is infected with the virus associated with such syndrome.

(b) RESTRICTION ON SCOPE OF SURVEY.—In conducting (or arranging for) the survey under subsection (a), the Secretary shall assure that survey activities do not duplicate research activities conducted by the Centers for Disease Control.

(c) REPORT.—Not later than 12 months after the date of enactment of this Act, the Secretary shall report to the Congress on the results of the survey conducted under subsection (a) and shall make recommendations to the Congress with respect to improving the care of infants and children with acquired immune deficiency syndrome who lack ongoing parental involvement and support.

SEC. 9139. TECHNICAL CORRECTIONS.

(a) The last sentence of section 472(a) of the Social Security Act is amended by striking out "473(a)(1)(B)" and inserting in lieu thereof "473(a)(2)(B)".

(b) Section 201(b)(2)(B) of the Immigration Reform and Control Act of 1986 is amended by striking out "Section 473(a)(1) of such Act" and inserting in lieu thereof "Section 473(a)(2) of such Act (as amended by section 1711(a) of the Tax Reform Act of 1986)".

PART 3—CHILD SUPPORT ENFORCEMENT AMENDMENTS

SEC. 9141. CONTINUATION OF CHILD SUPPORT ENFORCEMENT SERVICES TO FAMILIES NO LONGER RECEIVING AFDC.

(a) IN GENERAL.—(1) Section 457(c) of the Social Security Act is amended to read as follows:

"(c) Whenever a family with respect to which child support enforcement services have been provided pursuant to section 454(4) ceases to receive assistance under part A of this title, the State shall provide appropriate notice to the family and continue to provide such services, and pay any amount of support collected, subject to the same conditions and on the same basis as in the case of the individuals to whom services are furnished pursuant to section 454(6), except that no application or other request to continue services shall

be required of a family to which this subsection applies, and the provisions of section 454(6)(B) may not be applied.".

(2) Section 454(5) of such Act is amended by striking "(except as provided in section 457(c))".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall become effective upon enactment.

SEC. 9142. CHILD SUPPORT ENFORCEMENT SERVICES REQUIRED FOR CERTAIN FAMILIES RECEIVING MEDICAID.

(a) IN GENERAL.—Section 454 of the Social Security Act is amended—

(1)(A) by striking "an assignment under section 402(a)(26) of this title" in paragraph (4)(A) and inserting "an assignment under section 402(a)(26) or section 1912";;

(B) by striking ", and" at the end of paragraph (4)(A) and inserting ", or, in the case of such a child with respect to whom an assignment under section 1912 is in effect, the State agency administering the plan approved under title XIX determines pursuant to section 1912(a)(1)(B) that it is against the best interests of the child to do so, and"; and

(C) by inserting "or medical assistance under a State plan approved under title XIX" immediately after "aid to families with dependent children" in paragraph (4)(B); and

(2)(A) by striking "provide that," and inserting "provide that (A)" in paragraph (5); and

(B) by striking the semicolon at the end of paragraph (5) and inserting "; and (B) in any case in which support payments are collected for an individual pursuant to the assignment made under section 1912, such payments shall be made to the State for distribution pursuant to section 1912, except that this clause shall not apply to such payments for any month after the month in which the individual ceases to be eligible for medical assistance;".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall become effective on July 1, 1988.

SEC. 9143. REPEAL OF UNNECESSARY CHILD SUPPORT REVOLVING FUND.

(a) IN GENERAL.—Section 452(c) of the Social Security Act is amended to read as follows:

"(c) The Secretary of the Treasury shall from time to time pay to each State for distribution in accordance with the provisions of section 457 the amount of each collection made on behalf of such State pursuant to subsection (b).".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to amounts collected after the date of the enactment of this Act.

PART 4—UNEMPLOYMENT COMPENSATION

SEC. 9151. DETERMINATION OF AMOUNT OF FEDERAL SHARE WITH RESPECT TO CERTAIN EXTENDED BENEFITS PAYMENTS.

For the purpose of determining the amount of the Federal payment to any State under section 204(a)(1) of the Federal-State Extended Unemployment Compensation Act of 1970 with respect to the implementation of paragraph (3) of section 202 (a) of such Act (as added by section 1024(a) of the Omnibus Reconciliation Act of 1980),

such paragraph shall be considered to apply only with respect to weeks of unemployment beginning after October 31, 1981, except that for any State in which the State legislature did not meet in 1981, it shall be considered to apply for such purpose only with respect to weeks of unemployment beginning after October 31, 1982.

SEC. 9152. DEMONSTRATION PROGRAM TO PROVIDE SELF-EMPLOYMENT ALLOWANCES FOR ELIGIBLE INDIVIDUALS.

(a) IN GENERAL.—The Secretary of Labor (hereinafter in this section referred to as the "Secretary") shall carry out a demonstration program under this section for the purpose of making available self-employment allowances to eligible individuals. To carry out such program, the Secretary shall enter into agreements with three States that—

(1) apply to participate in such program, and

(2) demonstrate to the Secretary that they are capable of implementing the provisions of the agreement.

(b) SELECTION OF STATES.—(1) In determining whether to enter into an agreement with a State under this section, the Secretary shall take into consideration at least—

(A) the availability and quality of technical assistance currently provided by agencies of the State to the self-employed;

(B) existing local market conditions and the business climate for new, small business enterprises in the State;

(C) the adequacy of State resources to carry out a regular unemployment compensation program and a program under this section;

(D) the range and extent of specialized services to be provided by the State to individuals covered by such an agreement;

(E) the design of the evaluation to be applied by the State to the program; and

(F) the standards which are to be utilized by the State for the purpose of assuring that individuals who will receive self-employment assistance under this section will have sufficient experience (or training) and ability to be self employed.

(2) The Secretary may not enter into an agreement with any State under this section unless the Secretary makes a determination that the State's unemployment compensation program has adequate reserves.

(c) PROVISIONS OF AGREEMENTS.—Any agreement entered into with a State under this section shall provide that—

(1) each individual who is an eligible individual with respect to any benefit year beginning during the three-year period commencing on the date on which such agreement is entered into shall receive a self-employment allowance;

(2) self-employment allowances made to any individual under this section shall be made in the same amount, on the same terms, and subject to the same conditions as regular or extended unemployment compensation, as the case may be, paid by such State; except that—

(A) State and Federal requirements relating to availability for work, active search for work, or refusal to accept suitable work shall not apply to such individual; and

(B) such individual shall be considered to be unemployed for purposes of the State and Federal laws applicable to unemployment compensation,

as long as the individual meets the requirements applicable under this section to such individual;

(3) to the extent that such allowances are made to an individual under this section, an amount equal to the amount of such allowances shall be charged against the amount that may be paid to such individual under State law for regular or extended unemployment compensation, as the case may be;

(4) the total amount paid to an individual with respect to any benefit year under this section may not exceed the total amount that could be paid to such individual for regular or extended unemployment compensation, as the case may be, with respect to such benefit year under State law;

(5) the State shall implement a program that—

(A) is approved by the Secretary;

(B) will not result in any cost to the Unemployment Trust Fund established by section 904(a) of the Social Security Act in excess of the cost which would have been incurred by such State and charged to such Fund if the State had not participated in the demonstration program under this section;

(C) is designed to select and assist individuals for self-employment allowances, monitor the individual's self-employment, and provide, as described in subsection (d), to the Secretary a complete evaluation of the use of such allowances; and

(D) otherwise meets the requirements of this section; and

(6) the State, from its general revenue funds, shall—

(A) repay to the Unemployment Trust Fund any cost incurred by the State and charged to the Fund which exceeds the cost which would have been incurred by such State and charged to such Fund if the State had not participated in the demonstration program under this section; and

(B) in any case in which any excess cost described in subparagraph (A) is not repaid in the fiscal year in which it was charged to the Fund, pay to the Fund an amount of interest, on the outstanding balance of such excess cost, which is sufficient (when combined with any repayment by the State described in subparagraph (A)) to reimburse the Fund for any loss which would not have been incurred if such excess cost had not been incurred.

(d) EVALUATION.—(1) Each State that enters into an agreement under this section shall carry out an evaluation of its activities under this section. Such evaluation shall be based on an experimental design with random assignment between a treatment group and a control group with not more than one-half of the individuals receiving assistance at any one time being assigned to the treatment group.

(2) The Secretary shall use the data provided from such evaluation to analyze the benefits and the costs of the program carried out under this section, to formulate the reports under subsection (g), and to estimate any excess costs described in subsection (c)(6)(A).

(e) FINANCING.—(1) Notwithstanding section 303(a)(5) of the Social Security Act and section 3304(a)(4) of the Internal Revenue Code of 1986, amounts in the unemployment fund of a State may be used by a State to make payments (exclusive of expenses of administration) for self-employment allowances made under this section to an individual who is receiving them in lieu of regular unemployment compensation.

(2) In any case in which a self-employment allowance is made under this section to an individual in lieu of extended unemployment compensation under the Federal-State Extended Unemployment Compensation Act of 1970, payments made under this section for self-employment allowances shall be considered to be compensation described in section 204(a)(1) of such Act and paid under State law.

(f) LIMITATION.—No funds made available to a State under title III of the Social Security Act or any other Federal law may be used for the purpose of administering the program carried out by such State under this section.

(g) REPORT TO CONGRESS.—(1) Not later than two years after the date of the enactment of this Act, the Secretary shall submit an interim report to the Congress on the effectiveness of the demonstration program carried out under this section. Such report shall include—

(A) information on the extent to which this section has been utilized;

(B) an analysis of any barriers to such utilization; and

(C) an analysis of the feasibility of extending the provisions of this section to individuals not covered by State unemployment compensation laws.

(2) Not later than four years after the date of the enactment of this Act, the Secretary shall submit a final report to the Congress on such program.

(h) FRAUD AND OVERPAYMENTS.—(1) If an individual knowingly has made, or caused to be made by another, a false statement or representation of a material fact, or knowingly has failed, or caused another to fail, to disclose a material fact, and as a result of such false statement or representation or of such nondisclosure such individual has received payment under this section to which he was not entitled, such individual shall be—

(A) ineligible for further assistance under this section; and

(B) subject to prosecution under section 1001 of title 18, United States Code.

(2)(A) If any person received any payment under this section to which such person was not entitled, the State is authorized to require such person to repay such assistance; except that the State agency may waive such repayment if it determines that—

(i) the providing of such assistance or making of such payment was without fault on the part of such person; and

(ii) such repayment would be contrary to equity and good conscience.

(B) No repayment shall be required under subparagraph (A) until a determination has been made, notice thereof and an opportunity for a fair hearing has been given to the person, and the determination has become final. Any determination under such subparagraph

shall be subject to review in the same manner and to the same extent as determinations under the State unemployment compensation law, and only in that manner and to that extent.

(i) DEFINITIONS.—For purposes of this section—

(1) the term "eligible individual" means, with respect to any benefit year, an individual who—

(A) is eligible to receive regular or extended compensation under the State law during such benefit year;

(B) is likely to receive unemployment compensation for the maximum number of weeks that such compensation is made available under the State law during such benefit year;

(C) submits an application to the State agency for a self-employment allowance under this section; and

(D) meets applicable State requirements,

except that not more than (i) 3 percent of the number of individuals eligible to receive regular compensation in a State at the beginning of a fiscal year, or (ii) the number of persons who exhausted their unemployment compensation benefits in the fiscal year ending before such fiscal year, whichever is lesser, may be considered as eligible individuals for such State for purposes of this section during such fiscal year;

(2) the term "self-employment allowance" means compensation paid under this section for the purpose of assisting an eligible individual with such individual's self-employment; and

(3) the terms "compensation", "extended compensation", "regular compensation", "benefit year", "State", and "State law", have the respective meanings given to such terms by section 205 of the Federal-State Extended Unemployment Compensation Act of 1970.

SEC. 9153. EXTENSION OF FUTA TAX.

(a) IN GENERAL.—Paragraphs (1) and (2) of section 3301 of the Federal Unemployment Tax Act (26 U.S.C. 3301) are amended to read as follows:

"(1) 6.2 percent in the case of calendar years 1988, 1989, and 1990; or

"(2) 6.0 percent in the case of calendar year 1991 and each calendar year thereafter;".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to wages paid on or after January 1, 1988.

SEC. 9154. TRANSFER OF FUNDS INTO THE FEDERAL UNEMPLOYMENT ACCOUNT AND THE EXTENDED UNEMPLOYMENT COMPENSATION ACCOUNT.

(a) IN GENERAL.—Section 901 of the Social Security Act (42 U.S.C. 1101) is amended by adding at the end the following new subsection:

"Transfers For Calendar Years 1988, 1989, and 1990

"(g)(1) With respect to calendar years 1988, 1989, and 1990, the Secretary of the Treasury shall transfer from the employment security administration account—

"(A) to the Federal unemployment account an amount equal to 50 percent of the amount of tax received under section 3301(1)

of the Federal Unemployment Tax Act which is attributable to the difference in the tax rates between paragraphs (1) and (2) of such section; and

"(B) to the extended unemployment compensation account an amount equal to 50 percent of such amount of tax received.

"(2) Transfers under this subsection shall be as of the beginning of the month succeeding the month in which the moneys were credited to the employment security administration account pursuant to subsection (b)(2) with respect to wages paid during such calendar years.".

(b) INCREASE IN THE LIMITATION ON THE AMOUNTS IN SUCH ACCOUNTS.—(1) Section 902(a)(2) of such Act (42 U.S.C. 1102(a)(2)) is amended by striking out "one-eighth" and inserting in lieu thereof "five-eighths".

(2) Section 905(b)(2)(B) of such Act (42 U.S.C. 1105(b)(2)(B)) is amended by striking out "one-eighth" and inserting in lieu thereof "three-eighths".

(c) CONFORMING AMENDMENTS.—(1) Section 905(b)(1) of such Act (42 U.S.C. 1105(b)(1)) is amended by striking out the last sentence thereof.

(2) Section 901(c)(3)(C) of such Act (42 U.S.C. 1101(c)(3)(C)) is amended by striking out "(i)" and all that follows through the period and inserting in lieu thereof "a tax rate of 0.6 percent.".

(d) EFFECTIVE DATE.—The amendments made by this section shall become effective on the date of the enactment of this Act.

SEC. 9155. INTEREST ON ADVANCES TO THE FEDERAL UNEMPLOYMENT ACCOUNT AND THE EXTENDED UNEMPLOYMENT COMPENSATION ACCOUNT.

(a) EXTENDED UNEMPLOYMENT COMPENSATION ACCOUNT.—Section 905(d) of the Social Security Act (42 U.S.C. 1105(d)) is amended—

(1) by striking out "(without interest)" and ", without interest,"; and

(2) by adding the following new sentence at the end: "Amounts appropriated as repayable advances for purposes of this subsection shall bear interest at a rate equal to the average rate of interest, computed as of the end of the calendar month next preceding the date of such advance, borne by all interest bearing obligations of the United States then forming part of the public debt; except that in cases in which such average rate is not a multiple of one-eighth of 1 percent, the rate of interest shall be the multiple of one-eighth of 1 percent next lower than such average rate.".

(b) FEDERAL UNEMPLOYMENT ACCOUNT.—Section 1203 of such Act (42 U.S.C. 1323) is amended—

(1) by striking out "(without interest)" and ", without interest,"; and

(2) by adding the following new sentence at the end: "Amounts appropriated as repayable advances for purposes of this subsection shall bear interest at a rate equal to the average rate of interest, computed as of the end of the calendar month next preceding the date of such advance, borne by all interest bearing obligations of the United States then forming part of the public debt; except that in cases in which such average rate is not a multiple of one-eighth of 1 percent, the rate of interest

shall be the multiple of one-eighth of 1 percent next lower than such average rate.".

(c) CONFORMING AMENDMENT.—Section 903(a)(1) of such Act (42 U.S.C. 1103(a)(1)) is amended by inserting "and interest" after "all advances".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to advances made on or after the date of the enactment of this Act.

SEC. 9156. CREDITING TO THE FEDERAL UNEMPLOYMENT ACCOUNT OF INTEREST EARNED ON ADVANCES TO THE STATES.

(a) IN GENERAL.—Section 1202 of the Social Security Act is amended by adding at the end the following new subsection:

"(c) Interest paid by States in accordance with this section shall be credited to the Federal unemployment account established by section 904(g) in the Unemployment Trust Fund.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to interest paid on advances made on or after the date of the enactment of this Act.

Subtitle C—Manufacturers Excise Tax on Certain Vaccines

SEC. 9201. MANUFACTURERS EXCISE TAX ON CERTAIN VACCINES.

(a) IN GENERAL.—Chapter 32 of the Internal Revenue Code of 1986 (relating to manufacturers excise taxes) is amended by inserting after subchapter B the following new subchapter:

"Subchapter C—Certain Vaccines

"Sec. 4131. Imposition of tax.
"Sec. 4132. Definitions and special rules.

"SEC. 4131. IMPOSITION OF TAX.

"(a) GENERAL RULE.—There is hereby imposed a tax on any taxable vaccine sold by the manufacturer, producer, or importer thereof.

"(b) AMOUNT OF TAX.—

"(1) IN GENERAL.—The amount of the tax imposed by subsection (a) shall be determined in accordance with the following table:

If the taxable vaccine is:	*The tax per dose is:*
DPT vaccine	*$4.56*
DT vaccine	*0.06*
MMR vaccine	*4.44*
Polio vaccine	*0.29.*

"(2) COMBINATIONS OF VACCINES.—If any taxable vaccine is included in more than 1 category of vaccines in the table contained in paragraph (1), the amount of the tax imposed by subsection (a) on such vaccine shall be the sum of the amounts determined under such table for each category in which such vaccine is so included.

"(c) TERMINATION OF TAX IF AMOUNTS COLLECTED EXCEED PROJECTED FUND LIABILITY.—

"(1) IN GENERAL.—If the Secretary estimates under paragraph (3) that the Vaccine Injury Compensation Trust Fund would

sources of funds which diminish the guaranty agency's ability to have sufficient resources to meet lender's claims including, but not limited to, the subrogation of loans to the Department of Eduction under 428(c)(8), delayed payment of reimbursement under 428(c)(1) or payments under 428(f), and the reduction in reserves caused by the return of federal advance funds required by previous statutes. The Managers expect that in assessing appeals by guaranty agencies the Secretary will take into account their most recent available certified financial statements. The Managers wish to stress it is not the intention of the Congress to either materially harm an agency's ability to fulfill its function in the guaranteed student loan program or to so financially weaken an agency so as to impair its function.

I. PROVISIONS RELATING TO MEDICARE

A. Medicare Provisions (Part A)

1. Hospital Prospective Payment Rates (Section 9201 of House bill; Sections 4001 (a), (e), (f), and (h), 4002(a), and 4004(d) of the Senate amendment).

Present law

(a) Basic Update Factor for PPS Hospitals.—The Social Security Amendments of 1983 (P.L. 98-21) authorized the Secretary to determine the rate of increase in the payment rates, known as the update factor, for hospitals included in the prospective payment system (PPS) for FY 1986 and thereafter, taking into account the recommendations of the Prospective Payment Assessment Commission (ProPAC).

The Emergency Extension Act of 1985 (P.L. 99-107, as amended) froze FY 1986 rates at FY 1985 levels until April 30, 1986, The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272) established the update factor for the final five months of FY 1986. It also authorized the Secretary to determine the update factors for FY 1987 and FY 1988, subject to an upper limit equal to the projected increase in the hospital market basket (the Secretary's estimate of the annual increase in the cost of goods and services used by hospitals in providing care).

The Omnibus Budget Reconciliation Act of 1986 (OBRA, P.L. 99-509) delayed until FY 1989 the Secretary's authority to establish the update factor and set the update factor for FY 1987 at 1.15 percent. The update factor for FY 1988 was set at 2 percentage points below the market basket increase.

The debt limit extension act, P.L. 100-119, provides that, for the period October 1 through November 20, 1987, payment rates for PPS hospitals are frozen at FY 1987 levels. On November 20, 1987, the extension period expired. For discharges occurring on or after November 21, 1987, the federal portion of the payment rate is based entirely on the national rate (rather than a blend of national and regional rates) and the national rate is increased by 2.7 percent. For the first 51 days of a cost reporting period beginning on or after October 1, 1987, the blend factors for the federal and hospital specific portions of the rate are frozen at 75 and 25 percent, re-

spectively, and the update factor for the hospital specific rate is zero percent. For discharges occurring on or after the 52nd day of such periods, the federal and hospital specific blend factors change to 100 and 0 percent, respectively (the hospital's payment is based entirely on the national rate). Under P.L. 100–119, all payments to hospitals made on or after November 21, 1987, are reduced by 2.324 percent.

(b) Adjustment for Hospitals in Large Urban Areas or in Rural Areas.—(1) Separate standardized amounts, the basic Federal payment rates for PPS hospitals, are calculated for urban and rural hospitals. The same annual update factor is used for both the urban and the rural rates.

(2) For each diagnosis-related group (DRG), the Secretary computes national and regional urban and rural DRG-specific prospective payment rates by multiplying the applicable standardized amount by a weighting factor for the DRG.

(3) For short-stay hospitals in Puerto Rico, the basic payment rate for discharges after October 1, 1987, is equal to 75 percent of a separately calculated Puerto Rico DRG-specific rate plus 25 percent of the discharge-weighted average of the national urban and national rural DRG-specific rates.

(c) Adjustment for Non-Labor Costs.—The Secretary divides each DRG prospective payment rate into a portion attributable to wages and wage-related costs and a portion attributable to non-wage operating costs. The portion attributable to wages is adjusted by an Area Wage Index. This index, computed for each urban area and for all rural areas combined in each State, measures the level of hospital wages in the area relative to the national average hospital wage level. The portion of the rate attributable to non-wage operating costs is not adjusted by area (except for hospitals in Alaska and Hawaii). The final DRG rate for an area is the sum of the adjusted wage portion and the unadjusted non-wage portion.

(d) Disproportionate Share Adjustment and Indirect Medical Education Payments.—(1) The portion of PPS payments to hospitals based on Federal rates is adjusted to provide additional payment for the indirect costs of medical education. For FY 1988 and 1989, this adjustment is equal to:

$$2.0 \times ((1 + r)^{.405} - 1)$$

where "r" equals the ratio of the hospital's full-time equivalent interns and residents to beds. Under this formula, a hospital with approved medical education programs receives an increase of approximately 8.1 percent in the Federal portion of its PPS payments for each 0.1 in the ratio of interns and residents to beds. For FY 1990 and later years, the adjustment is:

$$.5 \times ((1 + r)^{.5795} - 1)$$

or approximately 8.7 percent for each 0.1 in the ratio of interns and residents to beds.

(2) For discharges between May 1, 1986 and October 1, 1989, the portion of PPS payments to hospitals based on Federal rates is adjusted to provide additional payments to those hospitals serving a disproportionate share of low-income patients.

For hospitals in urban areas with 100 or more beds which receive at least 30 percent of their net inpatient revenues from State and local payments for indigent care, the adjustment is 15 percent. For other hospitals, a disproportionate patient percentage is computed, reflecting relative volumes of inpatient care to Medicare patients eligible for Supplemental Security Income payments and to patients eligible for Medicaid. Hospitals whose percentage exceeds specified thresholds receive an adjustment according to a formula based on the percentage. For urban hospitals with 100 or more beds, the adjustment cannot exceed 15 percent. (Different rules apply for smaller urban and for rural hospitals.)

(3) The authority for the disproportionate share adjustment expires October 1, 1989.

(e) Update for PPS-Exempt Hospitals.—Certain hospitals are exempt from PPS and continue to be reimbursed on a reasonable cost basis. Reimbursement is limited to a target amount which is increased annually. The percentage increase in the target amount for hospital cost reporting periods beginning in a fiscal year conforms to the update factor for PPS rates in the same fiscal year. For cost reporting periods beginning during FY 1988, OBRA provided for an increase of 2 percentage points below the market basket increase. For FY 1989 and subsequent years, the percentage increase was to be established by the Secretary, OBRA also authorized the Secretary to establish different update factors for PPS and PPS-exempt hospitals and to vary the factors among types of exempt hospitals or units. P.L. 100-119 provides that, for a hospital cost reporting period beginning in FY 1988, the target amount for the first 51 days of the period is limited to the amount in effect during the previous reporting period.

(f) Wage Index Survey.—The Secretary is required to re-estimate "from time to time" the wage indices used in computing PPS payments. No particular methodology for developing the indices is specified.

(g) ProPAC Report on Study of Separate DRG Rates for Urban and Rural Hospitals.—The Secretary is required, through FY 1989, to submit an annual report on the impact of PPS. The report for 1985 was required to include the results of a study of the feasibility and impact of eliminating or phasing out the separate urban and rural DRG payment rates.

(h) Clinic Hospital Wage Indices.—Certain hospitals which, prior to FY 1983, furnished some services ordinarily included in the DRG payment through related organizations and permitted those organizations to bill separately for those services under part B, have been permitted to continue this practice at the discretion of the Secretary.

House bill

(a) Basic Update Factor for PPS Hospitals.—Sets the FY 1988 update factor for PPS hospitals at 1.0 percent. For FY 1989, sets the update factor equal to the market basket percentage increase minus 4.2 percentage points. For FY 1990, sets the factor equal to the market basket percentage increase minus 1.7 percentage points. Provides that update factors for FY 1991 and subsequent years are to be determined by the Secretary.

(b) Adjustment for Hospitals in Large Urban Areas or in Rural Areas.—(1) Requires the Secretary to establish separate standardized amounts for large urban areas, other urban areas, and rural areas. Large urban areas are defined as urban areas with a population of more than 1,000,000, as determined by the Secretary on the basis of the most recent available Bureau of the Census population data.

Provides that for discharges occurring in fiscal years 1988, 1989, and 1990, the annual increase in the standardized amounts for hospitals in large urban areas and rural areas is equal to the update factor for that fiscal year plus one percentage point. For hospitals in other urban areas, the annual increase is equal to the update factor for the fiscal year.

Specifies that the separate FY 1988 annual increase percentages for hospitals in large urban and other urban areas are both applied to the single urban standardized amount for FY 1987. For FY 1989 and 1990 the percentages are applied to the separate FY 1988 and FY 1989 standardized amounts, respectively.

Specifies that, for FY 1991 and later years, the annual increase in the standardized amounts for hospitals in large urban, other urban, and rural areas is equal to the update factor determined by the Secretary.

(2) Provides that, for each DRG, the Secretary is to compute for each fiscal year national and regional large urban, other urban, and rural DRG-specific prospective payment rates by multiplying the large urban, other urban, or rural standardized amounts by a weighting factor for the DRG.

(3) Provides that the 25 percent national component of the Puerto Rico DRG-specific rates shall be the discharge-weighted average of the large urban, other urban, and rural DRG-specific rates.

(c) Adjustment for Non-Labor Costs.—Provides that the Secretary shall compute a non-wage price index for each area and shall adjust the non-wage portion of each DRG rate by this index.

Provides that, for FY 1988, 1989, and 1990, the non-wage index for each State is the ratio of the average (weighted by discharges) of the area wage indexes for that State to the national discharge-weighted average wage index. For FY 1991 and after, the Secretary is required to use an area-specific non-wage index reflecting the price level in each area for non-personnel goods and services relative to the national average price level.

Provides that, for any hospital, the increase or decrease in the payment rate per discharge resulting from this adjustment is limited to 1 percent of what would have been paid for the same discharge (excluding any extra payments under provisions for "outliers," cases with unusually high costs or long stays) without the adjustment. The Secretary is required to adjust the standardized amounts in order to ensure that the use of a non-wage index does not result in the aggregate, in higher or lower payments than would otherwise have been made.

Requires the Secretary to report to Congress on the development of the non-wage price factors no later than October 1, 1989.

(d) Disproportionate Share Adjustment and Indirect Medical Education Payments.—(1) Changes the formula for the FY 1988 and 1989 indirect medical education adjustment to:

$$2.0 \times ((1 + r)^{.3975} - 1)$$

The change reduces the adjustment to approximately 7.95 percent for each 0.1 in the ratio of interns and residents to beds.

(2) Increases the disproportionate share adjustment to 20 percent for large urban hospitals meeting the State and local indigent care revenue test. For other urban hospitals with over 100 beds qualifying for an adjustment, provides that the adjustment is no longer limited to a maximum of 15 percent.

(3) No provision.

(c) Update for PPS-Exempt Hospitals—Provides for annual increases in target amounts separate from the rate increases provided for PPS hospitals. Sets the increase for cost reporting periods beginning in FY 1988, excluding the first 51 days of such periods, at 2.0 percentage points below the market basket percentage increase. For FY 1989 and subsequent years, sets the increase equal to the projected increase in the market basket. The Secretary's authority to set the increase for PPS-exempt hospitals and to vary the rate of increase among types of exempt hospitals and units is eliminated.

(f) Wage Index Survey.—No provision.

(g) ProPAC Report on Study of Separate DRG Rates for Urban and Rural Hospitals.—No provision.

(h) Clinic Hospital Wage Indices.—No provision.

Effective dates.—The increase in the target amounts for PPS-exempt hospitals applies 51 days after the start of a cost reporting period beginning on or after October 1, 1987. All other changes are effective for discharges occurring on or after November 20, 1987.

Senate amendment

(a) Basic Update Factor for PPC Hospitals and Adjustment for Hospitals in Rural Areas.—Sets the FY 1988 update factor at 0.5 percent for hospitals paid at the urban rate and 3.7 percent for hospitals paid at the rural rate, for discharges occurring on or after January 1, 1988. Amends section 107 of P.L. 100–119 to clarify that the blend factors for the Federal and hospital specific portions of the rate are frozen at 75 percent and 25 percent, respectively, and that the update factor applicable for the hospital specific rate is zero percent during the first 51 days of the hospital's furst cost reporting period beginning on or after October 1, 1987. For FY 1989, sets the update factor (for both urban and rural hospitals) at the market basket percentage increase minus two percentage points; for FY 1990, sets the factor at the market basket increase minus 1.6 percentage points. For FY 1991 and subsequent years, the update factors are to be determined by the Secretary. The Secretary is authorized to set different update factors for urban and rural PPS hospitals.

(b) Adjustment for Hospitals in Large Urban Areas or in Rural Areas.—See item (a), above.

(c) Adjustment for Non-Labor Costs.—No provision.

(d) Disproportionate Share Adjustment and Indirect Medical Education Payments.—(1) Changes the formula for the FY 1988 and 1989 indirect medical education adjustment to:

$$1.56 \times ((1 + r)^{.405} - 1)$$

effective for discharges on or after January 1, 1988, and provides that this formula shall remain in effect through FY 1990. The change reduces the adjustment to appropriately 6.3 percent for each 0.1 in the ratio of interns and residents to beds.

For FY 1991 and later years, changes the formula to:

$$1.7 \times ((1 + r)^{.405} - 1)$$

The change reduces the adjustment to approximately 6.9 percent for each 0.1 in the ratio of interns and residents to beds. Conforming amendments clarify that the formula changes are to be taken into account in determining payments.

(2) No provision.

(3) Extends the disproportionate share adjustment to October 1, 1990.

(e) Update for PPS-Exempt Hospitals.—Provides for annual increases in target amounts separate from the rate increases provided for PPS hospitals. Sets the increase for cost reporting periods beginning in FY 1988, excluding the first 51 days of such periods, at 2.7 percent. For FY 1989 and FY 1990, sets the increase equal to the projected increase in the market basket. For FY 1991 and subsequent years, the Secretary is authorized to establish the increase. The Secretary retains the authority to vary the rates of increase among types of exempt hospitals and units.

(f) Wage Index Survey.—Requires the Secretary to re-compute the wage indices not later than October 1, 1989, and at least every 36 months thereafter. The indices are to be based on a survey, updated as appropriate of wages and wage-related costs for PPS hospital. To the extent the Secretary deems feasible, the survey is to measure earnings and paid hours of employment by occupational category and exclude data on wages and wage-related costs incurred in furnishing skilled nursing facility services. See also item 2(e).

(g) ProPAC report on Study of Separate DRG Rates for Urban and Rural Hospitals.—Requires that ProPAC evaluate the study conducted by the Secretary and report its conclusions and recommendations to Congress no later than March 1, 1988.

(h) Clinic Hospital Wage Indices.—Revises the method of calculating the wage index for the purpose of adjusting payments after December, 1986, to a hospital which has been allowed to continue permitting billing by related organizations. The Secretary would be required to include wage costs for employees of the related organizations who are directly involved in the delivery or administration of the care furnished by the related organization to the hospital's inpatients. Wage costs do not include costs of overhead or home office administrative salaries or costs incurred outside the hospital's Standard Metropolitan Statistical Area.

Effective dates.—(a-b) Applies to discharges on or after January 1, 1988. (d) The provision relating to the indirect medical education adjustment applies to discharges on or after January 1, 1988. The

provision on disproportionate share adjustments is effective on enactment. (e) Applies to cost reporting periods beginning in FY 1988, excluding the first 51 days of such periods. (f), (g), and (h) Enactment.

Conference agreement:

(a)–(b) Basic Update Factor for PPS Hospitals; Adjustment for Hospitals in Large Urban Areas or in Rural Areas.—The conference agreement includes the House provisions, with amendments. The update factor for FY 1988 is set at 1.5 percent for hospitals in large urban areas, at 1.0 percent for hospitals in other urban areas, and at 3.0 percent for hospitals in rural areas. For FY 1989, the update is the market basket percentage increase less 2.0 percentage points for large urban areas, less 2.5 percentage points for other urban areas, and less 1.5 percentage points for rural areas. For FY 1990 and subsequent years, the update factor for all areas is set equal to the market basket percentage increase.

The agreement establishes regional floors for the standardized amounts, effective for discharges occurring on or after April 1, 1988, and before September 30, 1990. The regional floor for a region is set equal to the higher of the national standardized amount, or the sum of 85 percent of the national standardized amount and 15 percent of the regional standardized amount.

(c) Adjustment for Non-Labor Costs.—The conference agreement substitutes the following for the House provision. The Prospective Payment Assessment Commission is required to conduct a study of hospital nonlabor costs and input prices; the study is to be completed by October 1, 1989. The agreement does not include provisions relating to the use of a non-wage index in the computation of DRG payment rates or requiring a report by the Secretary on non-wage price factors.

(d) Disproportionate Share Adjustment and Indirect Medical Education Payments.—The conference agreement includes the House provision, with amendments. The provision is effective for discharges occurring on or after October 1, 1988. The indirect medical education adjustment is reduced to approximately 7.7 percent for each 0.1 in the ratio of interns and residents to beds. The disproportionate share adjustment is increased to 25 percent for hospitals meeting the State and local indigent care revenue test.

The conferees are concerned that the Secretary has not proceeded expeditiously to implement the disproportionate share adjustment for hospitals which receive more than thirty percent of net patient revenues from State and local governmental sources. The conferees wish to reaffirm their expectation that the Secretary will proceed to implement this adjustment without delay.

The conference agreement also provides the Secretary with the authority to make disproportionate share payments, under certain circumstances, on behalf of an inpatient facility of a multi-facility provider where the individual facility qualifies for disproportionate share payments but the provider as a whole does not qualify for such payments. In order to qualify, the provider's inpatient facilities must be physically separate, the facility in question must provide the Secretary with information documenting its Medicare dis-

charges and the provider's Medicare allowable inpatient costs must exceed its Medicare payments for inpatient care.

The conferees intend that the Secretary will make a determination of the facility's disproportionate share payment percentage, separate from the provider as a whole, when the provider submits the necessary data, and that the Secretary will make disproportionate share payments on behalf of inpatient facilities which meet the disproportionate share criteria and the other criteria specified in this provision.

(e) Update for PPS-Exempt Hospitals.—The conference agreement includes the Senate amendment.

(f) Wage Index Survey.—The conference agreement includes the Senate amendment. The conferees intend that the Secretary implement any update of the wage index in a budget neutral manner.

(g) ProPAC Report on Study of Separate DRG Rates for Urban and Rural Hospitals.—The conference agreement includes the Senate amendment with a modification to provide that ProPAC also study the desirability of maintaining separate rates for large urban and other urban hospitals.

(h) Clinic Hospital Wage Indices.—The conference agreement includes the Senate amendment, with a modification to provide that the changes in wage index methodology will take effect October 1, 1988.

2. Rural Hospitals (Section 9202 of House bill; Sections 4081 (b), (g), (o), (p), 4082 and 4083 of Senate amendment.

Present law

(a) Revision of Standards for Including a Rural County in an Urban Area.—Hospitals located in a county which is outside the boundaries of a Metropolitan Statistical Area (MSA) as defined by the Office of Management and Budget (OMB) are deemed to be in a rural area. (One standard used by OMB in establishing whether a county is within an urban area is the proportion of the county's workers commuting to the central county of the area.) The Secretary has used a general exception authority to reclassify some rural counties as urban by regulation.

(b) Expansion of Swing-Bed Program.—Under certain conditions, rural hospitals with fewer than 50 beds may enter into an agreement with the Secretary under which beds are used both for inpatient care and, with reduced compensation, for extended care equivalent to that furnished by skilled nursing facilities (SNFs).

(c) Clarification of Sole Community Provider Status.—Hospitals meeting certain criteria may apply for "sole community hospital" status. The Secretary is required to provide a payment adjustment to cover the fixed costs of a sole community hospital with a decrease during a year of 5 percent or more in total inpatient case load due to circumstances beyond its control. This provision applies to cost reporting periods beginning befor October 1, 1988. PPS payments to sole community hospitals are based on a blend of 25 percent of a hospital-specific rate and 75 percent of the Federal regional rate.

(d) Medicare Classification of Rural Referral Centers.—Rural hospitals which have 500 or more beds, or which meet certain criteria regarding referral patterns and distance travelled by Medicare pa-

tients that receive inpatient care, are classified as rural referral centers. Other rural hospitals qualify for designation as rural referral centers if they: (1) have a case mix index at least equal to the lesser of the median case mix index value for all PPS hospitals located in urban areas (the national median) or the median index for all nonteaching hospitals located in urban areas in the same region (the regional median); (2) have total annual inpatient discharges equal to or greater than the lower of 5,000 or the median number of discharges for all urban hospitals located in the same region; and (3) meet at least one of three additional criteria regarding the specialty status of the medical staff, travel distances of Medicare patients or volume of referrals. Rural osteopathic hospitals must meet the same criteria except that the minimum number of annual discharges must be at least 3,000. By regulation, rural referral centers are reimbursed according to the Federal urban payment amount adjusted by the applicable rural wage index. OBRA provided that certain hospitals classified as rural referral centers on October 21, 1986, would retain this status through cost reporting periods beginning before October 1, 1989.

(e) Improving the Definition of Hospital Labor Market Areas.—Hospitals located in a county which is outside the boundaries of a Metropolitan Statistical Area as defined by the Office of Management and Budget (OBM) are deemed to be in a rural area. The Secretary has used a general exception authority to reclassify some rural counties as urban by regulation.

(f) Demonstration Projects to Maintain Access to Isolated and Financially Distressed Rural Sole Community Hospitals.—No provision.

(g) Grant Program for Rural Health Care Transition.—No provision.

(h) Office of Rural Health Policy.—No provision.

(i) Set Aside for Experiments and Demonstration Projects Relating to Rural Health Care Issues.—Various provisions of the Social Security Act, including section 1875, section 402 of the Social Security Amendments of 1967 and section 222 of the Social Security Amendments of 1972, authorize the Secretary to conduct experiments and demonstrations regarding the operation or administration of the Medicare and Medicaid programs, or related issues such as coverage or reimbursement policy.

House bill

(a) Revision of Standards for Including a Rural County in an Urban Area.—(1) Provides that a hospital in a rural county adjacent to one or more urban areas shall be treated as being in the urban area to which the greatest number of workers in the county commute, if the county meets the following conditions: (a) it would be considered an urban county except for failure to meet current standards relating to commuting; (b) at least 15 percent of the employed persons in the county commute to the central county of any adjacent urban area, or the total number of persons commuting in either direction between the rural county and any adjacent urban area (the sum of the number of county resident commuting to any central county plus the number of persons commuting into the rural county from any uraban area) is at least equal to 20 percent

of the employed persons in the rural county; and (c) the average hospital wage level in the county is at least equal to the average wage level for rural hospitals in the State and at least equal to 85 percent of the average hospital wage level in the urban area to which the greatest number of the county's workers commute.

(2) Requires the Secretary to recompute the basic PPS payment rates for discharges occurring during FY 1988 to ensure that the reclassification of counties is budget neutral.

(3) Provides that Watertown Memorial Hospital in Watertown, Wisconsin is deemed to be located in Jefferson County, Wisconsin for PPS purposes.

(b) Expansion of Swing-Bed Program.—Provides that rural hospitals with fewer than 100 beds may participate in the swing-bed program. Payment for extended care services furnished by hospitals with 50–99 beds is subject to additional conditions. First, if there is an available SNF bed in the geographic area, the extended care patient must be transferred within 5 week-days, unless the patient's physician certifies that transfer is not medically appropriate; the Secretary is to provide by regulation for notice by SNFs to hospitals of the availability of beds. Second, payment is prohibited for days of Medicare-covered extended care at the hospital during a cost reporting period which exceed 15 percent of the product of the number of days in the period and the average number of licensed beds at the hospital.

Requires the Secretary to report, no later than February 1, 1989, on the proportion of swing-bed admissions approved or denied by peer review organizations (PROs) and on ways of encouraging participation in the swing-bed program by hospitals with low occupancy rates in areas with a nursing home bed shortage.

(c) Clarification of Sole Community Provider Status.—Provides that hospitals meeting the criteria for sole community hospital status may receive a payment adjustment without assuming the status of a sole community hospital. Extends the volume adjustment provision through cost reporting periods beginning before October 1, 1990. Requires the Secretary to issue clarifying instructions relating to implementation of the volume adjustment no later than October 1, 1987. Requires ProPAC to report to Congress by March 1, 1988, on the appropriateness of the criteria used in designating hospitals as sole community hospitals.

(d) Medicare Classification of Rural Referral Centers.—Classifies rural hospitals which have 275 or more beds as rural referral centers. Requires the Secretary to adjust the PPS payment rates for rural hospitals for discharges occurring on or after November 20, 1987 and before October 1, 1988 to ensure that this provision is budget neutral. Requires the Secretary to study and report to the Congress no later than March 1, 1989, on the extent of rural referral centers Medicare inpatient profits and losses and the appropriateness of paying the centers at a rate other than the rate paid to urban hospitals outside large urban areas. Also requires the Secretary to recommend criteria to be used in designating rural referral centers for cost reporting periods beginning on or after October 1, 1989.

(e) Improving the Definition of Hospital Labor Market Areas.—Provides that a hospital in a rural county immediately adjacent to

an urban area may apply to have its payment rates determined using the wage index adjustment for that urban area if it can show that its labor-related costs, adjusted for occupational mix, are at least equal to the 25th percentile of such costs in the urban area, or the median of such costs in the case of an urban area with fewer than four hospitals. Applies for discharges occurring on or after November 20, 1987 and before October 1, 1990. Requires the Secretary to adjust the payment rates under PPS in the following year to insure that the provision is budget-neutral.

Requires the Secretary to report to Congress, no later than September 30, 1989, on an analysis of variation in wage levels within and among the areas used as the basis for the area wage level adjustment, including the effects of variation in occupational mix and fringe benefits.

For discharges occurring on after October 1, 1989, requires the Secretary to replace the current system of urban and Statewide rural labor market areas with new area definitions based on the findings of the required analysis and taking into account similarities in labor costs for similar skill mixes. (See also item 1(f) above.)

(f) Demonstration Projects to Maintain Access to Isolated and Financially Distresed Rural Sole Community Hospitals.—Requires the Secretary to conduct, in geographically diverse areas, 3-year demonstration projects to determine appropriate methods of strengthening the financial and managerial ability of isolated and financially distressed rural hospitals to provide high quality care. Methods could include cooperative arrangements with other providers, diversification, physician recruitment, and improved management systems. Hospitals eligible to participate would be Medicare-participating rural hospitals which are certified as sole community hospitals, which have an average occupancy rate of less than 50 percent, and the closure of which would result in a significant loss of beneficiary access to necessary services. The Secretary is authorized to waive Medicare requirements as necessary and to spend up to $5 million from the Hospital Insurance trust fund in each of fiscal years 1988, 1989, and 1990 to conduct the projects.

Requires the Secretary to evaluate the demonstration projects and to report to the House Ways and Means and Senate Finance Committees. A preliminary report on the providers selected is due 18 months after enactment. A final report, with recommendations for legislation, is due upon completion of the demonstrations.

(g) Grant Program for Rural Health Care Transition.—No provision.

(h) Office of Rural Health Policy.—No provision.

(i) Set Aside for Experiments and Demonstration Projects Relating to Rural Health Care Issues.—No provision.

Effective date.—(a) Applies for discharges occurring on or after November 20, 1987. (b) Applies to swing-bed agreements entered into after September 30, 1987. The volume adjustment provision of (c) is effective for reporting periods beginning on or after the date of enactment. (d) Applies for discharges occurring on or after November 20, 1987.

Senate amendment

(a) Revision of Standards for Including a Rural County in an Urban Area.—(1) Similar provision, except that certain residents of adjacent urban areas who commute to the rural county are not counted in the total number of persons commuting in either direction between the rural county and any adjacent urban area. Also the wage-related criteria in the House bill are not included. The total number of persons commuting is determined as the sum of the number of county residents who commute for employment to the central county or counties of any adjacent urban area, plus the number of persons who commute into the rural county from the central county of counties of any adjacent urban area. Thus, in determining if the total number of persons commuting in either direction is at least equal to 20 percent of the employed population of the rural county, persons who commute into the rural county from any adjacent urban area but not from the central county or counties of the area are excluded.

(2) Similar provision, except that the Secretary is required to adjust the payment rates for urban hospitals only to ensure that any reclassification of counties is budget neutral. Also, for purposes of calculating the area hospital wage index, counties which qualify as urban counties under this provision are treated as rural counties.

(3) Identical provision.

(b) Expansion of Swing-bed Program.—No provision.

(c) Clarification of Sole Community Provider Status.—Similar provision, except that the Secretary is required to issue instructions to fiscal intermediaries clarifying criteria and application procedures for hospitals seeking a volume adjustment, within 120 days after the date of enactment. Also does not require ProPac to report to Congress regarding the criteria used to designate sole community hospitals. Additional payments to hospitals that qualify for volume adjustments under this provision, but are not sole community hospitals, are capped at $10 million in FY 1988 and $12 million in FY 1989.

(d) Medicare Classification of Rural Referral Centers.—Classifies rurla hospitals which have 275 or more beds as rural referral centers. Also creates a new class of rural referral centers, any hospital which: (1) has a case mix index equal to or greater than both the median case mix index for all urban nonteaching hospitals in the nation and the median case mix index for all urban nonteaching hospitals located in the same region; (2) has 3,000 or more discharges annually; and (3) meet other criteria specified by the Secretary. Requires the Secretary to implement these amendments in a budget neutral manner. These amendments are effective for discharges occurring on or after January 1, 1988, in the case of any hospital whose application for referral center status is approved, if the application was submitted before April 1, 1988.

(e) Improving the Definition of Hospital Labor Market Areas.—No provision.

(f) Demonstration Projects to Maintain Access to Isolated and Financially Distressed Rural Sole Community Hospitals.—No provision.

(g) Grant Program for Rural Health Care Transition.—Requires the Secretary to establish a program of grants to small rural hospitals to modify the type or extent of the service they provide in order to respond to various changes in their circumstances (such as changes in clinical practice patterns or service populations or changes in the demand for impatient or ambulatory care, etc.).

Non-Federal government-owned and private not-for-profit hospitals which are located in rural areas, have less than 100 beds and provide patient services for a variety of medical conditions, are eligible to submit a grant application to the Governor of their state. Within 30 days of receipt, the Governor, or his agent, must forward the application to the Secretary with any comments deemed appropriate.

Requires the Secretary to make awards based on: the Governor's comments; impact on expenditures under Part A of Medicare and access to care for Medicare beneficiaries; the applicant's understanding of its local market and current unmet needs of the elderly or disabled; and coordination with other providers and community leaders.

Limits grant awards to a maximum of $50,000 per year over a two-year period. Permits grant funds to be used for any expenses of the project applied for, except that not more than one third of any grant may be spent for capital-related costs, and no grant funds may be used to retire debt from capital expenditures which precede the grant project. Exempts capital expenditures undertaken to implement an approved project from the provisions of section 1122.

Requires the grantee to furnish such information as the Secretary may require to evaluate the project. Requires the Secretary to report to the Congress at least every six months regarding the status and performance of the program, including comments and recommendations of private and public entities with an interest in rural health care. Also requires the Secretary to submit a final report within 180 days after all projects are completed.

Authorizes appropriations from the Federal Hospital Insurance Trust Fund of $15 million per year in FY 1989 and FY 1990.

(h) Office of Rural Health Policy.—Require the Secretary of Health and Human Services to establish in HHS an Office of Rural Health Policy to advise the Secretary regarding the effects of current and proposed policies under Medicare and Medicaid on the financial viability of small rural hospitals to attract and retain physicians and other health profesionals, and on access to, and quality of health care in rural areas. Requires the Director of this office to oversee compliance with section 1102(b) relating to rulemaking and publication of rules) and with requirements elsewhere in this bill (see item 9(j)), regarding publication of an impact analysis of any proposed or final regulation which is expected to have a significant impact on small rural hospitals. Also requires the Director to: (1) establish and maintain a clearinghouse for collection and dissemination of information regarding issues, research findings and innovations in the delivery of care in rural areas; (2) coordinate Department activities related to rural health care, and (3) provide information to the Secretary and others regarding the related activities of other federal agencies.

(i) Set Aside for Experiments and Demonstration Projects Relating to Rural Health Care Issues.—Requires the Secretary, beginning with fiscal year 1989, to allocate not less than ten percent of the total spending on experiments and demonstrations authorized by section 402 of the Social Security Amendments of 1967 or by the Social Security Amendments of 1972, to experiments and demonstration projects relating substantially to rural health care issues. Such projects may address issues such as the impact of the PPS on the financial viability of small rural hospitals, the effect of Medicare payment policies on the ability of rural areas and rural hospitals to attract and retain physicians and other professionals, the appropriateness of Medicare conditions of participation for small rural hospitals and the impact of Medicare policies on access to and quality of, health care in rural areas.

Requires the Secretary to develop and report annually to the Congress (as part of the Secretary's annual report on the operation of the Medicare program) an agenda of experiments and demonstration projects relating to rural health care issues that are in progress or proposed, and the amounts obilgated and actually spent on such projects in the current and most recent fiscal years.

Effective date.—The amendment made by the first part of (a) applies for discharges occurring on or after January 1, 1988; the other provisions of (a) are effective on enactment. The volume adjustment provision of (c) is effective for reporting periods beginning on or after October 1, 1987. (d) Applies for discharges occurring on or after January 1, 1988. The provisions of (g), (h), and (i) are effective on enactment.

Confernece agreement

Part A, Item 2

(a) Revision of Standards for Including a Rural County in an Urban Area.—The conference agreement includes the Senate amendment with modifications. The community criteria in the House provision are included. A hospital located in a rural county which meets the commuting criteria in this provision is treated as being in the appropriate adjacent urban area for discharges occurring on or after October 1, 1988. The Secretary is required to adjust the payment rates, for urban hospitals only, to assure that any reclassification of hospitals from rural to urban is budget neutral.

The conferees intend that the effect of this provision shall be limited to the treatment, for payment purposes, of the hospitals located in qualifying rural counties; the boundaries and population size of the adjacent urban area shall not be altered.

(b) Expansion of Swing-Bed Program.—The conference agreement includes the House provision.

(c) Clarification of Sole Community Provider Status.—The conference agreement includes the Senate amendment with modifications. Additional payments to hospitals that qualify for a volume adjustment under this provision, but are not designated sole community hospitals, are capped at $5 million in FY 1988 and $10 million in FY 1989. The explicit requirement that the Secretary issue instructions to the fiscal intermediaries clarifying the criteria and

application procedures for hospitals seeking a volume adjustment, is not included.

(d) Medicare Classification of Rural Referral Centers.—The conference agreement includes the House provision, effective for discharges occurring on or after April 1, 1988.

(e) Improving the Definition of Hospital Labor Market Areas.—The conference agreement does not include the House provision.

(f) Demonstration Projects to Maintain Access to Isolated and Financially Distressed Rural Sole Community Hospitals.—The conference agreement does not include the House provision.

(g) Grant Program for Rural Health Care Transition.—The conference agreement includes the Senate amendment with modifications. The statement of the purpose of the program is amended. Grants are intended to support projects designed to demonstrate appropriate methods of strengthening the financial and managerial ability of isolated and financially distressed rural hospitals to provide high quality care. Such methods could include cooperative arrangements with other providers, diversification, physician recruitment, and improved management systems. Eligibility for grants is restricted to private not-for-profit hospitals which meet the other criteria included in the Senate amendment. The exemption, from the provisions of section 1122, of capital expenditures undertaken to implement an approved project, is not included.

(h) Office of Rural Health Policy.—The conference agreement includes the Senate amendment.

(i) Set Aside for Experiments and Demonstration Projects Relating to Rural Health Care Issues.—The conference agreement includes the Senate amendment with modifications. The Secretary is required to set aside specified portions of total spending for experiments and demonstrations during the three-year period beginning with FY 1988. The Secretary is required to allocate at least an additional ten percent of the total spending on expriments and demonstrations to projects relating substantially to health care issues of inner-city areas. The list of issues such projects may address is modified to reference both inner-city hospitals and inner-city areas as well as rural hospitals and rural areas. The requirement that the Secretary report to the Congress annually regarding the agenda of projects and spending related to rural health issues is extended to include projects and spending related to health issues in inner-city areas.

3. Payments for Capital-Related Costs (Section 9203 of House bill; Section 4003 of Senate amendment).

Present law

(a) Reductions in Payments for Capital.—Inpatient hospital capital-related costs, such as depreciation and interest, are excluded from PPS payments and are reimbursed on a reasonable cost basis. OBRA required the Secretary to reduce capital payments from amounts otherwise allowable by 3.5 percent in FY 1987, 7 percent in FY 1988, and 10 percent in FY 1989. P.L. 100-119 maintained the payment reduction at the 3.5 percent level through November 20, 1987.

(b) Prospective Payment for Capital-Related Costs.—(1) The Social Security Amendments of 1983 (P.L. 98-21) required the Secretary,

beginning in FY 1987, to include inpatient capital-related costs in PPS payments. The Urgent Supplemental Appropriations Act of 1986 (P.L. 99-349) postponed the inclusion of capital until FY 1988. OBRA gave the Secretary the discretion to postpone inclusion until a subsequent fiscal year of his choosing, and prohibited him from issuing a final rule relating to capital prior to September 1, 1987. On September 1, the Secretary published a final rule providing for phased implementation of prospective payment of capital-related costs. P.L. 100-119 extended the prohibition against rulemaking through November 20, 1987.

(2) P.L. 98-21 also provided that, unless Congress enacted legislation relating to capital payment prior to October 1, 1986, the Secretary could make no payment to a hospital for capital costs related to expenditures obligated by the hospital after September 30, 1986, unless the expenditures had been approved by a State planning agency with which the Secretary had entered into an agreement for the review of proposed capital expenditures pursuant to section 1122(b) of the Act. P.L. 99-349 postponed the date on which the State review requirement would go into effect to October 1, 1987. The Secretary has contended that the inclusion in OBRA of amendments related to capital costs constituted the legislation needed to nullify the requirement for 1122(b) State review agreements.

(c) ProPAC Report on Adjustment for Hospital Occupancy.—No provision.

House bill

(a) Reductions in Payments for Capital.—Provides that the payment reduction percentage for portions of cost reporting periods beginning after November 20, 1987, is 8.5 percent. Extends the 10 percent FY 1989 reduction through FY 1990.

(b) Prospective Payment for Capital-Related Costs.—(1) Requires the Secretary to establish a prospective payment system for capital-related costs of PPS hospitals for cost reporting periods beginning in FY 1992, and removes his authority in FY 1992, and removes his authority to establish a system at any earlier date.

Requires the system to provide for payment on a per discharge basis with apporpriate weighting for the type of discharge. Permits adjustments for hospital occupancy rate and for variations in construction or capital costs by area or type of facility. Permits the Secretary to grant exceptions to reflect capital obligations or for other reasons.

The term "capital-related costs" has the meaning given to it by the Secretary as of September 30, 1987.

(2) Deletes the requirement for 1122(b) agreements with State agencies. Conforming amendments delete other requirements which would have applied only to a prospective payment system for capital costs implemented prior to FY 1991.

(c) ProPAC Report on Adjustment for Hospital Occupancy.—Requires ProPAC to study and report to the House Ways and Means and Senate Finance Committees, no later than May 1, 1988, on the suitability and feasibility of linking Medicare capital payment to hospital occupancy rates.

Effective Date.—(a) Applies to portions of cost reporting periods occurring after November 20, 1987. The requirement in section (b)

for establishment of a prospective payment system for capital is effective October 1, 1987. The conforming amendments removing provisions applicable to such a system prior to FY 1991 are effective for cost reporting periods beginning on or after October 1, 1987, as is the removal of the Secretary's discretion to establish prospective payment for capital prior to FY 1992. All other provisions are effective on enactment.

Senate amendment

(a) Reduction in Payments for Capital.—Sets the payment reduction percentage for FY 1988 at 12 percent and establishes a 12 percent reduction for FY 1989 and a 10 percent reduction for FY 1990. For FY 1988, the reduction applies for portions of cost reporting periods or discharges occurring during FY 1988 after January 1, 1988. The reductions for FY 1989 and 1990 apply to portions of cost reporting periods or discharges occurring during those years.

(b) Prospective Payment for Capital-Related Costs.—(1) Postpones until FY 1992 the Secretary's authority to include capital-related costs in PPS payments.

The Secretary is prohibited from changing the definition of capital-related costs or the methodology for computing payment for capital-related costs for any inpatient hospital services. Any regulation violating this rule and published between August 1, 1987, and enactment is void, and such a regulation would not be recognized for the purposes of Gramm-Rudman. The rule does not apply to any regulation implementing the payment reduction percentages for capital-related costs.

(2) No provision.

(c) ProPAC Report on Adjustment for Hospital Occupancy.—No provision.

Effective Date.—The change in payment reduction percentages is effective for portions of cost reporting periods or discharges occurring after January 1, 1988.

Conference agreement

(a) Reduction in Payments for Capital.—The conference agreement includes the Senate amendment, with modifications. The payment reduction is increased to 12 percent for FY 1988, effective for discharges or portions of cost reporting periods occurring on or after January 1, 1988. For discharges or portions of cost reporting periods occurring in FY 1989, the reduction is 15 percent. The payment reduction for FY 1990 is eliminated.

(b) Prospective Payment for Capital-Related Costs.—The conference agreement includes the House provision.

Under the agreement, capital-related costs will be added to the Prospective Payment System as of October 1, 1991.

At that point, hospitals will have had more than eight years since the Congress originally indicated its intent in 1983 to reimburse for capital-related costs on a prospective basis.

(c) ProPAC Report on Adjustment for Hospital Occupancy.—The conference agreement includes the House provision.

4. Extension of Reductions under Sequester Order (Section 4014 of Senate Amendment).

Present law

On November 20, 1987, the President issued a final sequester order pursuant to the requirements of the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987 (P.L. 100-119). Under the terms of the sequester order, Medicare benefit payments for services rendered on or after November 21 and before the end of the fiscal year are reduced by 2.324 percent, to yield an aggregate reduction in benefit payments of 2 percent over the entire fiscal year.

House bill

No provision.

Senate amendment

Provides that the reductions in Medicare payment amounts required by the final sequester order shall continue to be effective for all services through December 31, 1987.

Effective date.—Enactment.

Conference agreement

The conference agreement includes the Senate amendment, with a modification to provide that the reductions in Medicare payment amounts required by the sequester order shall continue to be effective for hospital inpatient services through March 31, 1988.

5. Reporting Hospital Information (Section 9204 of House bill; and Section 4001(d) of Senate amendment)

Present law

(a) In General.—The Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (P.L. 95-142) required the Secretary to establish within one year of enactment uniform reporting requirements for inpatient hospitals and other providers. The Social Security Amendments of 1983 required the Secretary to maintain, at least until September 30, 1988, a system for the reporting of cost information by PPS hospitals.

(b) Conformity of Hospital Cost Reporting Periods.—Under current practice, the cost reporting periods used for hospitals conform to the fiscal years used in hospitals' internal accounting systems.

(c) Hospital Cost Data Base.—No provision.

House bill

(a) In General.—Specifies that the existing reporting system is applicable only for cost reporting periods beginning prior to October 1, 1988, and establishes new specific reporting requirements for fiscal intermediaries and hospitals. Specifies minimum service, cost, revenue, and other information to be included in reports. Defines the term "class" of payer and allows the Secretary to define the terms "bad debt" and "charity care."

(1) Quarterly reporting by fiscal intermediaries.—Requires each fiscal intermediary to compile and submit a quarterly summary and hospital-specific report within 45 days after the end of each quarter. Reports are to be based on information received from hospitals during the previous 4 calendar quarters. Reports are to be

provided to the House of Ways and Means and Senate Finance Committee, the Administrator of the Health Care Financing Administration, the Congressional Budget Office, and the Congressional Research Service.

(2) Annual reporting by each hospital.—Requires each hospital to submit its annual report to the fiscal intermediary within 90 days after the end of the hospital's cost reporting period. Reports are to include a financial statement and other information necessary to complete the report to be filed by the fiscal intermediary. In the event of late filing, payments to the hospital for the second succeeding quarter are to be reduced by 5 percent. Allows multiple hospitals under the joint ownership or control of a health maintenance organization or similar entity to file consolidated reports.

Requires the Secretary to develop a system for annual reporting which is compatible with the needs of PPS and which facilitates the electronic transmission of the information in the reports. See item 5(c), below.

Requires the Secretary to publish a notice of proposed rulemaking relating to annual reports no later than June 30, 1988, and a final rule no later than September 30, 1988. Requires hospitals which receive more than $10 million in Medicare payments during a cost reporting period beginning in FY 1991 or a subsequent year (or any other hospital, at the Secretary's discretion) to file the annual reports electronically.

(b) Conformity of Hospital Cost Reporting Periods.—Requires each hospital, other than one owned by State or local government, to establish a cost reporting year ending on March 31, June 30, September 30, or December 31. Permits the Secretary to make grants of up to $100,000 from the Hospital Insurance Trust Fund to assist hospitals in changing to an accounting year ending on September 30.

(c) Hospital Cost Data Base.—No provision.

Effective date.—(a) Applies to hospital cost reporting periods beginning on or after October 1, 1988; (b) applies to cost reporting periods beginning on or after January 1, 1989.

Senate amendment

(a) In General.—No provision.

(b) Conformity of Hospital Cost Reporting Periods.—No provision.

(c) Hospital Cost Data Base.—Requires the Secretary to develop two data bases on operating costs of inpatient hospitals, one for a representative sample of hospitals, the other for all hospitals participating in Medicare.

Provides that the data base on the sample of hospitals would be for use by Congress and the Secretary in determining annual increases in PPS rates and target amounts for PPS-exempt hospitals, and for evaluating other payment adjustments and legislative, regulatory, or budgetary changes. In selecting the sample, the Secretary is to choose PPS hospitals with cost reporting periods beginning in the first 4 months of the Federal fiscal year and, to the extent practicable, provide adequate representation of small rural hospitals, sole community hospitals, and rural referral centers. The Secretary is required to report to Congress on this data base no later than October 1, 1988.

Provides that the Secretary is to develop and place into effect the data base for all hospitals no later than June 1, 1989. The data base would be updated at least once every quarter and include data for the 12-month period preceding each update. Data could be drawn from preliminary cost reports, so long as the Secretary made available an update analysis of the differences between preliminary and settled cost reports.

Provides that, for cost reporting periods beginning on or after October 1, 1989, the Secretary is required to place into effect a standardized electronic cost reporting format, developed in consultation with hospital industry representatives. The Secretary could delay or waive implementation of the format for small or rural hospitals, hospitals with a small percentage of Medicare volume, or others for whom implementation would result in financial hardship.

Effective date.—Enactment.

Conference agreement

The conference agreement includes the Senate amendment with modifications. The provision regarding the development of a data base from the sample of all PPS hospitals with cost reporting periods beginning in the first four months of the Federal fiscal year, is not included. The Secretary is required to conduct a demonstration project on hospital reporting in two states for a three year period. Within one year of enactment, the Secretary must develop a reporting format to collect information on hospital costs, revenues and charges, similar to the formats used in the statewide reporting systems in California and New York. The Secretary is required to implement the reporting format to collect data in two states for the remaining two years.

In selecting the two demonstration states, the Secretary must include one state which presently has a uniform reporting system. The conferees intend that the Secretary will select the State of California to meet this requirement. The Secretary is also required to select the second demonstration State from among those States which do not presently operate such a system. The conferees intend that compliance with the requirements of the new reporting system will be mandatory for all hospitals located in a demonstration State.

The Secretary is required to set aside at least $1 million per year from existing funds for research and demonstrations for development of the reporting format and at least $2 million per year from existing funds for program operations for data collection and analysis. Total funds expended for these projects may not exceed $15 million over the three year period.

The General Accounting Office (GAO) is required to evaluate the adequacy of the existing reporting system and the costs and benefits of the reporting system developed in the demonstration project. GAO is also required to make recommendations to the Congress regarding improvements in hospital reporting systems and in methods of data analysis and display to provide better support for policy making on hospital payment issues.

The conferees commend the Secretary for recent improvements in the transmittal of data from the hospital cost reporting system. However, further improvements can be attained. The conferees

wish to make clear that we (they) expect the Secretary to proceed expeditiously to analyze the data processing systems under his control in order the expedite the flow of data from hospital to intermediaries to decision-makers within the Department and the Congress.

6. Delay in Effective Date for Standards for Organ Procurement (Section 4080 of House bill; Section 4001(q) of Senate amendment).

Present law

The Omnibus Budget Reconciliation Act of 1986 provided that Medicare payments for organ procurement would not be made unless the organ procurement agency involved met specified requirements and was designated by the Secretary as the sole procurement agency for its service area.

The law also required Medicare-participating hospitals to establish protocols for making a routine inquiry for organ donation by potential donors. In addition, it required all hospitals performing transplants, as a prerequisite to participation in Medicare, to be members of the National Organ Procurement and Transplantation Network.

Under the Omnibus Budget Reconciliation Act of 1986, these provisions were originally to be effective as of October 1, 1987. The Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987, however, changed this effective date to November 21, 1987.

House bill

Extends the effective date by which the Secretary must complete the organ procurement agency designation process to April 1, 1988.

Effective date.—Enactment.

Senate amendment

Extends to December 31, 1988, the effective date by which the Secretary must complete the organ procurement agency designation process, the effective date for the requirements for hospital protocols for organ procurement, and the effective date for requiring hospitals to be members of the Network.

Effective date.—Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986.

Conference agreement

The conference agreement includes the Senate amendment with modifications. The delay would only apply to the designation of organ procurement organizations, effective March 31, 1988. Payments for organ procurement would be assured as if this provision had been included in OBRA.

7. Raising Threshold for Prospective Payment for Skilled Nursing Facilities to 2,500 Patient Days (Section 9205 of House bill)

Present law

Skilled nursing facilities (SNFs) which provided fewer than 1,500 days of care per year to Medicare patients during the preceding cost reporting period are offered the option of being paid a prospective rate rather than being reimbursed retrospectively on the basis

of reasonable costs actually incurred. By accepting the prospective payment method, these SNFs have fewer paperwork requirements.

The prospective payment rates are set at 105 percent of the average per diem reasonable routine service and capital-related costs of routine SNF services for all urban and rural skilled nursing facilities in the region. The rates are separately calculated for SNFs located in urban areas and for SNFs located in rural areas. The prospective rates exclude the reasonable costs of ancillary services; these costs are reimbursed separately. The rates also are adjusted to reflect differences in wage levels among urban areas and rural areas within each region. The prospective urban or rural regional per diem rate for a SNF may not exceed the per diem routine service cost limit otherwise applicable to that facility after taking into account differences in average per diem capital costs by type and location of facility.

Prospective payment on this basis took effect for facilities that elected such payment for cost reporting periods beginning on or after October 1, 1986.

House bill

Raises the maximum number of days of care from 1,500 to 2,500 a SNF may provide to Medicare beneficiaries before losing the option of prospective payment.

Effective date.—Applies to cost reporting periods beginning on or after October 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

8. Nursing Home Reforms (Sections 9211-9214 and 4111-4117 of House bill; Section 4051 of Senate amendment)

See: "E. Medicare and Medicaid Nursing Home Standards Reform Provisions".

9. Miscellaneous and Technical Provisions Relating to Part A (Section 9206 of House bill; Sections 4001 (c), (k) (l), (m), (n), and 4086 of Senate amendment)

Present law

(a) Responsibilities of Medicare Hospitals in Emergency Cases.—A hospital participating in the Medicare program which has an emergency department is generally required to provide emergency treatment sufficient to stabilize the patient's condition to any person who comes to the hospital with an emergency medical condition or in active labor. If the hospital determines that such a condition exists, it must (1) provide, within its capabilities, examination and treatment to stabilize the medical condition or to administer to the labor; or (2) provide for an appropriate transfer to another medical facility if a physician certifies that the benefits of the transfer outweigh the increased risks (or if the patient requests the transfer).

A hospital which violates these requirements is subject to suspension or termination of its Medicare provider agreement. The

hospital and the responsible physician are each subject to a civil monetary penalty of not more than $25,000 for each violation.

(b) Clarification of Section 1886(c) State Waiver Authority.—State hospital cost control systems which received their waivers before the enactment of the Social Security Amendments of 1983 (the law which established Medicare's prospective payment system for inpatient hospitals) may have their effectiveness judged in one of two ways. The Secretary normally judges the system's effectiveness on the basis of the State's rate of increase in total Medicare payments for hospital inpatient services as compared to the national rate of increase in such payments. At the request of the State, however, the Secretary is required to judge the system's effectiveness on the basis of the rate of increase in aggregate payments per admission or per discharge in the State as compared to the rate of increase in the nation.

The Secretary may deny such a request for cost reporting periods beginning on or after October 1, 1986.

(c) Clarification of Section 1814(b) State Waiver Authority.—Under certain conditions, the Secretary may continue payment to hospitals under an alternative State hospital reimbursement system, which was initially established as a demonstration under Section 402 of the Social Security Amendments of 1967 or Section 222 of the Social Security Amendments of 1972, until the Secretary determines that: (1) a third party payer reimburses a hospital in the State on a basis other than the alternative system; or (2) the rate of increase in Part A costs per inpatient hospital admission for the previous 3-year period is greater than the national rate of increase in such costs.

(d) Continuation of Bad Debt Recognition for Hospital Services.—By regulation, Medicare reimburses hospitals for Medicare bad debt, defined as the unrecovered costs associated with unpaid Medicare deductible and coinsurance amounts. In order for the unpaid deductible and coinsurance amounts to be considered bad debt, the amounts must be related to covered services furnished to a beneficiary and the hospital must meet certain collection criteria.

(e) Hospital Outlier Payments and Policy.—Under the prospective payment system (PPS), additional amounts are paid to hospitals for cases, known as outliers, which have extremely long lengths of stay or extraordinary high costs compared to most patients classified in the same diagnosis related group (DRG). Cases which have a length of stay which exceeds the applicable length of stay threshold for the DRG are paid 60 percent of a per diem amount for each covered day beyond the threshold. Cases which do not qualify as "day" outliers but have estimated costs in excess of the applicable cost threshold for the DRG ("cost outliers") are paid 60 percent of costs above the threshold. The 60 percent factor, applied in determining extra payments for day and cost outliers, is determined by the Secretary in regulations.

The law requires that total outlier payments to all hospitals represent no less than 5 percent nor more than 6 percent of the total PPS payments based on the DRGs projected for the fiscal year. Outlier payments are financed by an offsetting reduction in the Federal portion of the DRG rates, with separate set-aside factors for urban and rural hospitals.

In a notice published on June 10, 1987, the Secretary proposed to make substantial changes in the payment policy for outlier cases, effective for discharges occurring during fiscal year 1988. In the final notice published on September 1, 1987, however, the Secretary decided not to adopt any change in the current policy.

(f) Miscellaneous Accounting Provision.—The Omnibus Budget Reconciliation Act of 1986 requires the Secretary to treat certain hospitals with accounting years ending on September 27, 28, or 29 as if the accounting years ended on September 30.

(g) Designation of Pediatric Hospitals as Meeting Certification as Heart Transplant Facility.—Under current law, the Secretary certifies cardiac transplant centers for Medicare participation and for Medicare reimbursement for transplant services. Under current regulations, no pediatric centers are certified.

(h) Waiver of Inpatient Limitations for Connecticut Hospice, Inc.—Medicare-certified hospices are required to maintain no more than 20 percent of total days as inpatient days. The remaining percentage of days would be home care days. The Omnibus Budget Reconciliation Act of 1986 provided a 2-year waiver (until October 1, 1988) for Connecticut Hospice, Inc. from the 20 percent/80 percent inpatient/home care day requirement, provided that the percentage of inpatient days does not exceed 50 percent.

(i) Revision of Appointment Process for Prospective Payment Assessment Commission.—When appointing members to the Prospective Payment Assessment Commission (ProPAC), the Director of the Office of Technology Assessment (OTA) is required to consult with a variety of national organizations in seeking nominations.

(j) Rural Impact Regulatory Analysis.—There is currently no requirement that the Secretary include, in a proposed final rule, an analysis of the regulation's impact on rural areas.

(k) Psychologists Services Furnished to Hospital Inpatients.—Inpatient hospital services covered under Medicare include the category of "other diagnostic or therapeutic items or services, furnished by the hospital or others under arrangements with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or others under such arrangements." Under this category Part A covers the inpatient hospital services of psychologists employed by or providing services under arrangements with hospitals.

(l) Hospital Condition of Participation Related to Individual Responsible for Care of Patient.—Medicare's conditions of participation for hospitals require that every patient at the hospital be under the care of a physician. Medicare does not generally include psychologists under the definition of a physician.

Under some State laws, a psychologist may admit a patient to a hospital and treat the patient. The Civilian Health and Medical Program of the Uniform Services (CHAMPUS) and the Federal Employees Health Benefits Act (FEHBA) currently allow coverage of services of psychologist in accordance with State law.

Because Medicare's conditions of participation apply to all patients in the hospital, not only to Medicare patients, the Medicare conditions may negate State law and the CHAMPUS and FEHBA policies for any Medicare-participating hospital.

(m) Technical Part A Amendments.—(1) Technical Changes.—Current law contains a number of technical errors.

(2) Disproportionate Share Hospitals.—Additional payments are made to PPS hospitals that serve a disproportionate share of low-income patients. Under one criterion, a hospital located in an urban area, which has 100 or more beds, may receive such payments if it can demonstrate that more than 30 percent of its inpatient care revenues (excluding any Medicare or Medicaid revenues) are provided by State and local government payments for indigent care.

There has been controversy over the interpretation of current statutory language which refers to inpatient care revenues as "net inpatient care revenues" in one location, but refers to "such revenues" has been interpreted to mean either gross inpatient revenues (revenues the hospital would receive if all patients paid the hospital's full charges) or net inpatient revenues (gross revenues minus bad debts, contractual allowances, and charity care).

House bill

(a) Responsibilities of Medicare Hospitals in Emergency Cases.—Increases the maximum civil monetary penalty to $50,000 and authorizes the Secretary to bar physicians who violate the requirements from participating in the Medicare program for up to five years.

Effective date.—Applies to actions occurring on or after the date of enactment of this Act.

(b) Clarification of Section 1886(c) State Waiver Authority.—Clarifies that either the State or the entity responsible for the operation of the State hospital cost control system, may exercise the option regarding the basis on which the Secretary judges the system's effectiveness.

Effective date.—Applies to cost reporting periods beginning on or after October 1, 1983.

(c) Clarification of Section 1814(b) State Waiver Authority.—Requires the Secretary, in comparing the rate of increase in Medicare costs per admission for the alternative reimbursement system with the rate of increase for all hospitals, to make the comparison over the period from October 1, 1983 to the end of the most recent date for which annual data are available.

Effective date.—Enactment.

(d) Continuation of Bad Debt Recognition for Hospital Services.—Prohibits the Secretary from making any change in policy in effect on August 1, 1987 on payments for Medicare bad debt.

Effective date.—Enactment.

(e) Hospital Outlier Payments and Policy.—(1) Increase in Outlier Payment for Burn Center DRGs.—Increases payments for outlier cases classified in DRGs relating to burns by changing the percentage factor applied in determining outlier payments from 60 percent to 90 percent. Thus burn cases which stay beyond the appropiate day outlier threshold would receive 90 percent of the applicable per diem for each outlier day. Cost outliers in burn DRGs would receive 90 percent of the cost of care above the cost outlier threshold. This reimbursement level would apply to discharges occurring during fiscal years 1988 and 1989.

(2) Burn Study.—Requires the Secretary to study the PPS payment amounts for burn cases. The Secretary is required to recommend to Congress appropriate adjustments to these amounts to assure that the costs of treating burn patients are being adequately reimbursed.

(3) Limitation on Changes in Outlier Regulations.—Prohibits the Secretary from issuing any final regulation which changes the method of payment for outlier cases, after the date of enactment of this Act and before October 1, 1988.

(4) Study on Outlier Payments.—Requires the Chairman of the Prospective Payment Assessment Commission to report to Congress and the Secretary, by not later than June 1, 1988, on the method of payment for outlier cases.

Effective date.—Enactment.

(f) Miscellaneous Accounting Provision.—Amends prior law for hospitals with accounting years ending on September 27, 28, or 29 in 1985 and are located in a State in which inpatient hospital services were paid in fiscal year 1985 pursuant to a statewide demonstration project under Section 402 of the Social Security Amendments of 1967 and Section 222 of the Social Security Amendments of 1972. If such a hospital elects, by notice to the Secretary by January 1, 1988, the hospital would receive payments for: (1) the first 7 months of the cost reporting period, which began during September 1985, at a 75 percent hospital-specific rate and a 25 percent DRG rate; and (2) the remaining 5 months at a 50 percent hospital-specific rate and a 50 percent DRG rate.

Effective date.—Applies as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986.

(g) Designation of Pediatric Hospitals as Meeting Certification as Heart Transplant Facility.—Requires the Secretary to determine that a pediatric hosptial meets the criteria of a Medicare heart transplant facility if: (1) the hospital's pediatric heart transplant program is operated jointly by the hospital and another facility that meets such criteria, (2) the unified program shares the same transplant surgeons and quality assurance program (including oversight committee, patient protocol, and patient selection criteria), and (3) the hospital demonstrates to the satisfaction of the Secretary that it is able to provide the specialized facilities services, and personnel that are required by pediatric heart transplant patients. (See also Item 9, Part II.B.)

Effective date.—Enactment.

(h) Waiver of Inpatient Limitations for Connecticut Hospice, Inc.—Provides that the existing 2-year waiver from the 20 percent/80 percent inpatient/home care day requirement is permanently waived.

Effective date.—Enactment.

(i) Revision of Appointment Process for Prospective Payment Assessment Commission.—Section 9206.—Repeals the requirement that the OTA Director seek nominations from various organizations. The OTA Director is required to appoint individuals with national recognition for their expertise in health economics, hospital reimbursement, hospital financial management, and other related fields.

Section 4075 and 4076.—No provision.

Effective date—

Section 9206.—Applies to appointments made after the date of enactment of this Act.

(j) Rural Impact Regulatory Analysis.—

Section 9206.—Requires the Secretary—in publishing notices of proposed and final regulations relating to Part A of Medicare—to include an analysis of the impact of such regulations on health care in rural hospitals.

Effective date.—

Section 9206.—Applies to regulations (and proposed regulations) issued on or after January 1, 1988.

Section 4073.—Applies to regulations published more than 120 days after the date of enactment of this Act.

(k) Psychologists Services Furnished to Hospital Inpatients.—No provision.

(l) Hospital Condition of Participation Related to Individual Responsible for Care of Patient.—No provision.

(m) Technical Part A Amendments.—(1) Technical Changes.—Corrects a number of technical errors.

(2) Disproportionate Share Hospitals.—Clarifies that a hospital would qualify if more than 30 percent of its net inpatient care revenues (excluding any Medicare or medicaid revenues) are provided by State and local government payments for indigent care.

Effective date.—Enactment.

Senate amendment

(a) Responsibilities of Medicare Hospitals in Emergency Cases.—No provision.

(b) Clarification of Section 1886(c) State Waiver Authority.—No provision.

(c) Clarification of Section 1814(b) State Waiver Authority.—Similar provision.

Effective date.—Enactment.

(d) Continuation of Bad Debt Recognition for Hospital Service.—Similar provision, except that it specifies that the Secretary is prohibited from issuing regulations to alter the method in effect on March 31, 1987 for making payments for Medicare bad debt (including criteria for what constitutes a reasonable collection effort).

Effective date.—Enactment.

(e) Hospital Outlier Payments and Policy.—(1) Increase in Outlier Payments for Burn Center DRGs.—Similar provision, except that it includes a budget neutrality provision and clarifies that, it shall apply to discharges occurring on or after January 1, 1988, and before October 1, 1989.

(2) Burn Study.—Requires ProPAC to conduct a study of possible modifications to PPS that will provide more adequate and appropriate payments with respect to burn outlier cases, including a recommendation with respect to whether separate payment rates should be established for burn center hospitals. ProPAC is required to report the results of the study to the Congress by April 1, 1988.

(3) Limitation on Changes in Outlier Regulations.—No provision.

(4) Study on Outlier Payments.—Requires the Secretary to include in the annual report to Congress regarding the operation and administration of the Medicare program a comparison of hospitals

located in an urban area and hospitals located in a rural area regarding the amount of reductions and additional payments for outliers.

Effective date.—(1) Applies to discharges occurring on or after January 1,1988, and before October 1, 1989, (2) and (4) Enactment.

(f) Miscellaneous Accounting Provision.—No provision.

(g) Designation of Pediatric Hospitals as Meeting Certification as Heart Transplant Facility.—No provision.

(h) Waiver of Inpatient Limitation for Connecticut Hospice, Inc.—Identical provision.

Effective date.—Enactment.

(i) Revision of Appointment Process for Prospective Payment Assessment Commission.—No provision.

(j) Rural Impact Regulatory Analysis.—Requires the Secretary—whenever he or she publishes a general notice of proposed rulemaking for any rule or regulation proposed under Medicare, Medicaid, or the peer review organization program, that may have a significant impact on a substantial number of small rural hospitals—to prepare and make available for public comment an initial regulatory impact analysis.

Requires that analysis to describe the impact of the proposed rule or regulation on such hospitals and is required to set forth, with respect to small rural hospitals, the matters required under Section 603 of Title V, United States Code—to be set forth with respect to small entities.

Requires the initial regulatory impact analysis (or a summary) to be published in the Federal Register at the time of the publication of general notice of proposed rulemaking for the rule or regulation.

Requires the Secretary—whenever he or she promulgates a *final* version of a rule or regulation for which an initial regulatory impact analysis is required by the above—to prepare a final regulatory impact analysis with respect to the final version of the rule or regulation.

Requires that analysis to describe the impact of the proposed rule or regulation on such hospitals and is required to set forth, with respect to small rural hospitals, the matters required under Section 603 of Title V, United States Code—to be set forth with respect to small entities.

Requires the Secretary to make copies of the final regulatory impact analysis available to the public and to publish, in the Federal Register at the time of publication of the final version of the rule or regulation, a statement describing how a member of the public may obtain a copy of such analysis.

Requires—if a regulatory flexibility analysis is required by Chapter 6 of Title V, United States Code, for a rule or regulation to which this subsection applies, such analysis shall specifically address the impact of the rule or regulation on small rural hospitals.

Effective date.—Applies to regulations proposed more than 30 days after the date of the enactment of this Act.

(k) Psychologists Services Furnished to Hospital Inpatients.—Specifies that Medicare coverage for "other diagnostic or therapeutic items or services" furnished to hospital inpatients by "others under arrangements with them made by the hospital" includes the services of clinical psychologists (as defined by the Secretary). This

provision clarifies that Part A covers the inpatient hospital services of clinical psychologists.

Effective date.—Enactment.

(l) Hospital Condition of Participation Related to Individual Responsible for Care of Patient.—Modifies Medicare's conditions of participation so that the requirement that every patient at the hospital be under the care of a physician applies only to Medicare patients at the hospital, thereby allowing State law to apply to other patients.

Effective date.—Enactment.

(m) Technical Part A Amendments.—No provision.

Conference agreement

(a) Responsibilities of Medicare Hospitals in Emergency Cases.—The conference agreement includes the House provision.

(b) Clarification of Section 1886(c) State Waiver Authority.—The conference agreement includes the House provision with a modification. The conference agreement does not include the clarification contained in the House provision. The conference agreement prohibits the Secretary from recouping, or otherwise reducing payments to Massachusetts hospitals for any alleged overpayments which may have occurred during the period of the Waiver agreement, through January 1, 1989.

(c) Clarification of Section 1814(b) State Waiver Authority.—The conference agreement includes the House provision.

The conferees note that there is confusion regarding the application of the sequester to Medicare payments to providers paid under a waiver held by the State of New Jersey. The State of New Jersey is free to provide an update to hospitals, subject to the terms of its waiver. No reduction in payments under the sequester is intended beyond the reduction experienced by other hospitals.

(d) Continuation of Bad Debt Recognition for Hospital Services.—The conference agreement includes the House provision, with an amendment to prohibit the Secretary from modifying the criteria for what constitutes a reasonable collection effort) in effect on March 31, 1987.

(e) Hospital Outlier Payments and Policy.—The conference agreement includes the House provision with modifications. The budget neutrality provision required by the Senate amendment is included. The conference agreement also requires the Secretary to include in the annual report to Congress (regarding the operation and administration of the Medicare program) a comparison of the amount of reductions and additional payments for outliers for hospitals located in an urban area and hospitals located in a rural area. The conference agreement does not include the ProPAC study of the method of payment for outliers required by the House provision.

(f) Miscellaneous Accounting Provision.—The conference agreement includes the House provision.

(g) Designation of Pediatric Hospitals as Meeting Certification as Heart Transplant Facility.—The conference agreement includes the House provision.

The conferees note that the conference agreement should not be construed as an endorsement of the provision of cardiac transplant services by consortia of hospitals.

(h) Waiver of Inpatient Limitations for Connecticut Hospice, Inc.—The conference agreement includes the House provision.

(i) Revison of Appointment Process for Prospective Payment Assessment Commission.—The conference agreement includes the House provision, with a modification to require the Commission to include a mix of professionals, broad geographic representation, and balance between urban and rural representatives.

(j) Rural Impact Regulatory Analysis.—The conference agreement includes the Senate amendment.

(k) Psychologists Services Furnished to Hospital Inpatients.—The conference agreement includes the Senate amendment.

(l) Hospital Condition of Participation Related to Individual Responsible for Care of Patients.—The conference agreement includes ths Senate amendment.

(m) Technical Part A Amendments.—The conference agreement includes the House provisions.

10. Elimination of Periodic Interim Payment System (PIP) for Certain Hospitals (Section 4004(a)–(c) of Senate Amendment).

Present law

OBRA requires the Secretary, under certain circumstances, to continue making payments to PPS hospitals for inpatient services furnished to Medicare beneficiaries on a periodic interim payment (PIP) basis, rather than on the basis of bills actually submitted.

One such circumstance involves certain disproportionate share hospitals (DSH), hospitals which receive additional payments under PPS because they serve a disproportionate share of low income patients. A DSH which has a disproportionate share adjustment percentage of at least 5.1 percent, continues to receive periodic interim payments if it meets certain conditions: (1) it requests such payments; (2) it was being paid on that basis as of June 30, 1987, and (3) it continues to meet the other eligibility requirements that were in effect on October 1, 1986. P.L. 100–119 provides that a law or regulation that has the effect of transferring outlays or revenues from one fiscal year to an adjacent fiscal year cannot be treated as altering the budget deficit, unless it meets certain conditions such as, including a stipulation that the transfer "is a necessary (but secondary) result of a significant policy change".

House bill

No provision.

Senate amendment

Prohibits payment on the basis of periodic interim payments for disproportionate share hospitals on or after July 1, 1990.

Authorizes the Secretary to continue payments to a DSH on a PIP basis after that date (for such period as the Secretary deems appropriate) if the hospital demonstrates to the Secretary that discontinuing PIP payments would pose an immediate threat to the hospital's ability to operate.

Requires the Secretary to defer the PIP payments that would otherwise be made to any DSH hospitals during at least the last 21 days of fiscal year 1989, until fiscal year 1990.

Stipulates that the transfer of outlays due to this provision "is a necessary (but secondary) result of a significant policy change".

Effective date.—Effective on enactment.

Conference agreement

The conference agreement does not include the Senate amendment.

B. Medicare Provisions (Parts A and B)

1. Prompt Pay Standard (Sections 9231 and 4074. of House bill; Sections 4011 (a) ands (c) of Senate amendment).

Present law

At least 95 percent of "clean" claims for Part A services (for Medicare claims not paid on periodic interim payment basis) are required to be paid within 30 calendar days after the day on which a clean claim is recieved in FY 1987, 26 days in FY 1988, 25 days in FY 1989, and 24 days in FY 1990 and thereafter. A clean claim is one which has no defect or impropriety (including lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevent timely payment from being made

If payment is not made for these part A claims by the applicable number of days after the date on which a clean claim is received, interest is required to be paid beginning on the day after the date on which payment was due, and ending on the date payment is made.

The requirements for part B claims are similar, except that for participating physicians the applicable number of days for 95 percent of clean claims to be paid is 19 days in FY 1988, 18 for FY 1989, 17 for FY 1990 and thereafter. Interest accrues for payment not paid within the specified time period.

Current law does not contain any standard regarding the average time over which clean claims shall be paid.

Under P.L. 100-119, the Sercretary is prohibited from taking any action primarily intended, to delay the processing of claims until November 21, 1987.

House bill

(a) Average Time Period.—

Section 9331.—Requires the Secretary to manage a claims payment policy resulting in a specified average time period between receipt of a clean claim and payment by fiscal intermediaries and carriers. In FY 1988, this policy is to apply only to Part A; the average time period will be 20 days. In fiscal years 1989 and 1990, this policy will apply to both Part A and Part B. The average time period will be 23 days in FY 1989 and 25 days in FY 1990.

Requires the Secretary to publish in the Federal Register notice of the particular average payment period required of each fiscal intermediary and carrier for the fiscal year. The notice shall be pub-

lished (within 30 days after the enactment for FY 1988 and before September 1, 1988 and September 1, 1989 for fiscal years 1989 and 1990, respectively).

Requires the Secretary to provide, to the maximum extent feasible, consistent with the time periods established, that the difference between the average payment period required of each intermediary or carrier for a fiscal year and the actual average payment period of the intermediary or carrier for the previous fiscal year shall be approximately equal.

Section 4074.—Prohibits the Secretary from delaying payments to achieve an increase in the average period of payments under Part B.

(b) Payment Floor Standards.—No provision.

(c) General Accounting Office Report.—

Section 9231.—Requires the Comptroller General to review and report, by March 31, 1988, to the House Committee on Ways and Means and the Senate Committee on Finance on the implementation of the amendments made by this section.

Section 4074.—No provision.

(d) Prohibition of Other Policies Intended to Slow Down Medicare Payments.—

Section 9231.—Prohibits the Secretary from issuing, after the date of enactment of this Act and before October 1, 1990, any other final regulation, instruction, or other policy change (other than those needed to implement this provision) which is primarily intended to have the effect of slowing down claims processing, or delaying payment of claims.

Section 4074.—No provision. [See (a) above.]

(e) Conforming Amendments to Prompt Payment Provisions.—

Section 9231.—Increases the applicable number of days by which at least 95 percent of "clean" claims for Part A services (for Medicare claims not paid on a periodic interim payment basis) are required to be paid for each of the next three fiscal years. For Part A and for Part B, (other than for participating physicians), the ceiling is 28 calendar days for fiscal years 1988, 1989, and 1990 (and 24 days thereafter). For participating physicians the ceiling is 21 calendar days for fiscal years 1988, 1989, and 1990 (and 17 days thereafter).

Section 4074.—No provision.

(f) Budget Considerations.—No provision.

Effective date.—

Section 9231.—Applies on or after October 1, 1987.

Section 4074.—Applies on or after the date of enactment of this Act.

Senate amendment

(a) Average Time Period.—No provision.

(b) Payment Floor Standards.—Establishes a payment floor for Part A and Part B claims, requiring that no Medicare claim shall be issued, mailed, or otherwise transmitted within the applicable number of calendar days after the date on which the claim is received. The applicable number of days shall be 10 days for claims received in the 3-month period beginning July 1, 1988, 11 days for

the 12-month period beginning October 1, 1988, and 12 days for the 12-month period beginning October 1, 1989.

Requires the Secretary to provide for such timely amendments to agreements with fiscal intermediaries, contracts with carriers, and regulations, to the extent necessary to implement these provisions on a timely basis.

(c) General Accounting Office Report.—No provision.

(d) Prohibition of Other Policies Intended to Slow Down Medicare Payments.—No provision.

(e) Conforming Amendments to Prompt Payment Provisions.—No provision.

(f) Budget Considerations.—Provides that for purposes of Section 202 of the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987, this section [(b) above] is a necessary (but secondary) result of a significant policy change.

Effective date.—(b) Applies to claims received on or after July 1, 1988. (f) Enactment.

Conference agreement

(a) Average Time Period.—The conference agreement does not include the House provision.

(b) Payment Floor Standards.—The conference agreement includes the Senate amendment, with modifications. The applicable number of days shall be 10 days for the 3-month period beginning July 1, 1988, and 14 days for the 12-month period beginning October 1, 1988.

(c) General Accounting Office Report.—The conference agreement does not inlcude the House provision.

(d) Prohibition of Other Policies Intended of Slow Down Medicare Payments.—The conference agreement includes the House provision.

(e) Conforming Amendments to Prompt Payment Provisions.—The conference agreement does not include the House provision.

(f) Budget Consideration.—The conference agreement includes the Senate amendment.

2. Health Maintenance Organization (HMOs) and Competitive Medical Plans (CMPs) (Sections 9232, 4023, and 4079 of the House bill; Section 4092 of the Senate amendment

Present law

(a) Broadening Use of Civil Monetary Penalties and Intermediate Sanctions Against HMOs/CMPs.—HMOs/CMPs must provide assurances to the Secretary that they will not expel or refuse to reenroll any individual on the basis of health status or need for health services.

For each instance in which an HMO/CMP fails substantially to provide medically necessary items and services to a beneficiary, the Secretary may impose a $10,000 civil monetary penalty. No other sanctions short of contract termination are available for most other kinds of possible HMO/CMP contract or legal violations.

(b) Capitation Demonstration Projects.—The Secretary is authorized to waive provisions of the Act in order to conduct demonstration projects.

(c) Treatment of Michigan Blue Care HMO Network under 50 Percent Rule.—In order to qualify for a Medicare risk contract, an HMO or CMP must have an enrolled population of which not more than 50 percent are Medicare or Medicaid beneficiaries. Blue Care, a Michigan Blue Cross/Blue Shield subsidiary, enrolles individuals and then assigns them to individual HMOs also owned by Michigan Blue Cross/Blue Shield. If Blue Care is the corporate entity contracting directly with Medicare, the 50 percent test would be applied to Blue Care, rather than the individual HMOs contracting with Blue Care.

(d) Assignment of HMO Members for Certain Organizations.—If an HMO or CMP establishes an affiliate or subsidiary as an independent wholly-owned corporation and the affiliate seeks a Medicare risk contract, it must meet the 50 percent test on its own, regardless of the population of the parent organization.

(e) Coverage of Social Worker Services Furnished by an HMO to Its Members.—HMOs, CMPs must make available to Medicare enrollees the full range of Medicare-covered services. In addition, they are responsible for services not ordinarily coverd by Medicare; services of a nurse practitioner or clinical psychologist are covered if the same services would be covered by Medicare if it had been provided by a physician.

(f) Delay in Effective Date of Physician Incentive Rules for Health Maintenance Organizations.—OBRA provided for civil money penalties if a hospital or an HMO contracting with Medicare or Medicaid made a direct or indirect payment to a physician as an inducement to reduce or limit services to beneficiaries under his or her care; the physician receiving the payment could also be penalized. For HMOs and CMPs, the provision applies to such payments made on or after April 1, 1989.

(g) Temporary Waiver for Watts Health Foundation.—An HMO/CMP with a Medicare risk contract must have an enrolled population of which not more than 50 percent are Medicare or Medicaid beneficiaries. Waivers are permitted under certain conditions. OBRA narrowed the conditions for waivers but provided that an HMO/CMP which had a waiver in effect on the date of enactment could be permitted to retain the waiver if the Secretary determined that it was making reasonable efforts to comply with the 50 percent limit or to adhere to a schedule of compliance. The Secretary is authorized to impose sanctions if the organization fails to adhere to an agreed schedule.

(h) Extension of Waivers for Social Heath Maintenance Organizations.—The Deficit Reduction Act of 1987 (DEFRA, P.L. 98-369) required the Secretary to grant 3-year waivers for demonstrations of social health maintenance organizations, which provide integrated health and social services on a prepaid capitated basis. The Secretary was required to submit a final report on the demonstrations to Congress no later than 42 months after enactment (that is, by January 1988).

(i) HMO Payments for Hospital Services.—An HMO/CMP with a Medicare risk contract may elect to have the Medicare program pay directly for hospital inpatient and skilled nursing facility services which are furnished to beneficiaries and for which the HMO/

CMP is liable. The amounts expended are deducted from future payment to the HMO/CMP.

(j) Discount and Advance Determination of Payments.—Payment rates for an HMO/CMP are established annually.

(k) Post-Contract Protection for CMP Enrollees.—Priority under the Bankruptcy Code.—No provision.

(l) Task force on Medicare Capitation.—No provision.

(m) Disabled Individual Classification.—In computing the adjusted average per capita cost (AAPCC) for HMO/CMP rate setting, the Secretary may establish classes of beneficiaries according to age, disability status, and other factors. The Secretary has established classes of disabled beneficiaries under age 65 and classes of beneficiaries aged 65 and over, but no distinct class of persons who are both disabled and aged 65 and over.

(n) Two-Year Extension on Period for Benefit Stabilization.—Each HMO/CMP must develop an adjusted community rate (ACR), an estimate of what it would charge a private member comparable to a Medicare beneficiary for the scope of services covered under its Medicare contract. If an HMO/CMP's ACR is lower than its average project Medicare capitation payment, the HMO/CMP must use the difference to fund supplemental benefits or accept a reduced capitation rate. Alternatively, it may request that a portion of the difference be deposited in a benefit stabilization fund (within the Part A and Part B Trust Funds). The fund may be drawn upon in a future year if the difference between the ACR and the Medicare capitation rate is insufficient to continue financing the HMO/CMP's package of supplemental benefits. A stabilization fund may not be established for any contract period beginning more than 4 years after the enactment of the Deficit Reduction Act of 1984, or July 18, 1988.

(o) Notice to enrollees.—No provision.

House bill

(a) Broadening Use of Civil Monetary Penalties and Intermediate Sanctions Against HMOs/CMPs.—

Section 9232.—Provides that HMOs/CMPs may not engage in any practice which can reasonably be expected to deny or discourage (on the basis of health status) enrollment or reenrollment.

Provides that the Secretary may impose civil monetary penalties or sanctions when he determines that an HMO/CMP denies medically necessary services, imposes charges on enrollees in excess of those permitted by law, violates provisions relating to expulsion of or refusal to reenroll enrollees, enrolls beneficiaries without their knowledge or consent, or misrepresents or falsifies information provided to the Secretary or an enrollee regarding costs, benefits or services provided.

Provides for civil monetary penalties of not more than $25,000 for each violation; penalties may be not more than $100,000 for cases of denial of enrollment on the basis of health status or falsification of information provided to the Secretary. The Secretary may also suspend new enrollments or suspend payments to the HMO/CMP until he is satisfied that violations will not recur. Incorporates existing provisions on administration of civil monetary penalties.

Sections 4023 and 4079.—No provision.

(b) Capitation Demonstration Projects.—

Section 9232.—Prohibits the Secretary from conducting any demonstration projects which involves capitation payments to an organization not eligible for an HMO/CMP contract and which (1) will result in Medicare expenditures of more than $15,000,000 in any year without the specific authorization and direction of Congress; or (2) provides for a capitated payment rate in excess of the rates payable to risk-contracting HMOs under current law. The Comptroller General is required to report annually to Congress on any such demonstration conducted with an organization which is eligible for an HMO/CMP contract.

Sections 4023 and 4079.—No provision.

(c) Treatment of Michigan Blue Care HMO Network under 50 Percent Rule.—

Section 9232.—Provides that Blue Care may be deemed to meet the 50 percent Medicare and Medicaid enrollment limit if each of the participating HMOs separately meets the limit for its enrollees or assignees and no more than 20 percent of the enrollees or assignees of each HMO are Medicare beneficiaries.

Sections 4023 and 4079.—No provisions.

(d) Assignment of HMO Members for Certain Organizations.—

Section 9232.—Permits the enrollees of a subdivision, subsidiary, or affiliate HMO to have its members considered as members of the parent organization for the purposes of the 50 percent test during the period before October 1, 1992. The parent organization must have contracted with a State Medicaid agency to provide prepaid services prior to 1970, and must have members with a collectively bargained right to obtain services through the organization. The affiliate must meet all eligibility standards except the 50 percent test and must be wholly owned or controlled by the parent organization. The parent organization must guarantee the quality and solvency of the affiliate.

Sections 4023 and 4079.—No provision.

(e) Coverage of Social Worker Services Furnished by an HMO to Its Members.—

Section 4023.—Adds to the list of additional services covered for HMO or CMP enrollees services of a clinical social worker, along with services and supplies incident to such services, when the services would have been covered by Medicare if provided by a physician. Educational and experience criteria for clinical social workers are defined, with separate criteria for States which do and do not provide for licensure or certification of social workers.

Section 9232.—No provision.

(f) Delay in Effective Date of Physician Incentive Rules for Health Maintenance Organizations.—

Section 4079.—Delays the effective date of the rule for HMOs/CMPs to April 1, 1990.

Section 9232.—No provision.

(g) Temporary Waiver for Watts Health Foundation.—No provision.

(h) Extension of Waivers for Social Health Maintenance Organizations.—No provision.

(i) HMO Payments for Hospital Services.—No provision.

(j) Discount and Advance Determination of Payments.—No provision.

(k) Post-Contract Protection for CMP Enrollees.—Priority under the Bankruptcy Code.—No provision.

(l) Task Force on Medicare Capitation.—No provision.

(m) Disabled Individual Classification.—No provision.

(n) Two-Year Extension on Period for Benefit Stabilization.—No provision.

(o) Notice to enrollees.—No provision.

Effective date.—

Section 9232.—Enactment.

Section 4023.—Applies to services performed on or after January 1, 1988.

Section 4079.—Enactment.

(a) Broadening Use of Civil Monetary Penalties and Intermediate Sanctions Against HMOs/CMPS.—Increases the civil monetary penalty for failure to furnish medically necessary services to $25,000 for each failure. The Secretary may also impose civil monetary penalties or sanctions when he determines that an HMO/CMP imposes premiums on enrollees in excess of those permitted by law, violates provisions relating to expulsion of or refusal to re-enroll enrollees, engages in any practice which can reasonably be expected to deny or discourage (on the basis of health status) enrollment or reenrollment, or misrepresents or falsifies information provided to the Secretary, an enrollee, or any other entity. Civil monetary penalties for these kinds of violations may be not more than $10,000 for each violation. The Secretary may also suspend new enrollments or suspend payments to the HMO/CMP until he is satisfied that violations will not recur. Incorporates existing provisions on administration of civil monetary penalties.

(b) Capitation Demonstration Projects.—Requires the Secretary to conduct demonstrations to test alternative capitation payment methodologies. Demonstrations would be conducted in each of three areas:

(1) Computing a health status adjustment in the adjusted average per capita cost (AAPCC).

(2) Contracting with employer-related groups for voluntary enrollment of employees in a managed care program, with rates set on an experience basis.

(3) Accounting for geographic variations in cost in computing the AAPCC, considerating geographic bases which may provide more equitable payment than is provided by setting the AAPCC on a county-by-county basis. Demonstrations on this subject would be conducted primarily in geographic areas where HMO/CMP payment rates are below 80 percent of the median AAPCC for all counties within metropolitan statistical areas and could include HMOs/CMPs in urban areas which primarily serve populations from counties in which payment rates were below that percentage.

Requires the Secretary in carrying out the demonstrations to appoint, in consultation with the Congress, a panel of specialists to review the project and make recommendations on rate setting and measures to ensure quality of care. Authorizes $5 million in each of

fiscal years 1989 and 1990 for the demonstrations relating to geographic adjustments in rate setting.

(c) Treatment of Michigan Blue Care HMO Network under 50 Percent Rule.—Similar provision.

(d) Assignment of HMO Members for Certain Organizations.—Similar provision.

(e) Coverage of Social Worker Services Furnished by an HMO to Its Members.—No provision.

(f) Delay in Effective Date of Physician Incentive Rules for Health Maintenance Organizations.—No provision.

(g) Temporary Waiver for Watts Health Foundation.—Provides that an organization which had a pre-OBRA waiver of the 50 percent limit and which received at least $3 million in Public Health Service community or migrant health center grant funds in FY 1987 is exempt from the 50 percent limit until January 1, 1990. After that date, the organization would be eligible for a waiver on the same terms and subject to the same conditions as other HMO/CMPs.

(h) Extension of Waivers for Social Health Maintenance Organizations.—Required the Secretary to extend the waivers through September 30, 1992, under the same terms and conditions as under DEFRA. The Secretary is required to submit an interim report by January 1988, and a final report no later than March 31, 1993.

(i) HMO Payments for Hospital Services.—Reappeals the provision allowing direct Medicare payment of HMO/CMP hospital and skilled nursing facility charges. In the case of an HMO/CMP which had elected the direct payment option prior to October 1, 1987, hospitals or skilled nursing home facilities furnishing services to the HMO/CMP's Medicare enrollees are required to accept as payment in full from the HMP/CMP the amounts that would have been paid for the same services furnished to nonenrollees under Medicare reimbursement principles. The Secretary is required to furnish such an HMO/CMP with information (in machine readable form) on Medicare payment rates and cost passthroughs for inpatient services.

(j) Discount and Advance Determination of Payments.—Provides that the Secretary may, at the request of an HMO/CMP, enter into a multi-year contract and establish the annual rates for each year of the contract when the contract is entered into. The Secretary is permitted to discount the rates as he deems appropriate before entering into the contract.

(k) Post-Contract Protection for CMP Enrollees.—Priority under the Bankruptcy Code.—Requires an eligible organization which is not a federally qualified HMO to make assurances (satisfactory to the Secretary) that, if it should cease to provide services under the contract, it will provide or arrange supplemental coverage to enrolled beneficiaries. Supplemental coverage would continue for the duration of any exclusion period related to a preexisting condition.

Amends chapter 11 of the Bankruptcy Code to provide that, in the event a CMP enters a chapter 11 proceeding, the CMP (or its trustee) must make timely payments for the required supplemental coverage. Payments made prior to approval of a reorganization plan would be treated as an administrative expense. The reorganization plan would have to provide for continuation of the payments

to the extent necessary to comply with the assurances made to the Secretary.

(l) Task Force on Medicare Capitation.—Establishes a 15-member Task Force on Medicare Capitation, to be appointed by the Prospective Payment Assessment Commission (ProPAC), in consultation with the Physician Payment Review Commission (PPRC), after consultation with private and prepaid health plans. Membership would consist of 5 members drawn from each of the following groups:

(i) Representatives of private and prepaid health plans; these could include physicians or other health professionals serving Medicare beneficiaries;

(ii) Researchers in health care delivery and financing and experts in prepaid health care financing and underwriting;

(iii) Medicare beneficiaries and representatives of employers and labor.

Members are to serve for the life of the Task Force. A vacancy is to be filled by a member of the appropriate group, appointed in the same manner as the original appointee. Replacement of a member would not affect the powers or duties of the Task Force.

Provides that a majority of the Task Force members shall constitute a quorum and that decisions may be made by a simple majority of members present and voting at a properly called meeting. The first meeting is to be called by ProPAC no later than January 1, 1988. Task Force members are to select a Chairman. Subsequent meetings are to occur at the call of the Chairman or a majority of members, but no less than once every 3 months.

Provides that members are to serve without pay but receive travel expenses and per diem allowances according to the rules for persons serving intermittently in Government service.

Provides that the Task Force shall:

(i) Periodically review the calculations and methodology employed by the Secretary in establishing the capitation rate for an HMO/CMP with a risk contract;

(iii) Document and report on discrepancies between the actual and projected U.S. per capita incurred cost (USPCC) used in rate-setting, with particular attention to calendar years 1985, 1986, and 1987; and

(iii) Assess alternative rate-setting methodologies.

Requires the Task Force to submit a final report to Congress no later than January 1, 1989. The Secretary is required to provide interim reports, no later than January 1, 1989 and 1990, describing the Task Force's activities and giving any preliminary findings on the subjects to be addressed in the final report.

Provides that the Task Force's final report shall include:

(i) An assessment of the long-term potential for Medicare savings through prepared health plans;

(ii) A comparative analysis of use, cost, and quality of services under fee-for-service systems and prepaid plans;

(iii) An evaluation of the geographic areas used in developing capitation rates, the use of fee-for-service reimbursement and utilization rates in calculating rates, and the effect on the rate calculation of substantial market penetration by prepaid plans;

(iv) Recommendations for changes in the Medicare rate-setting methodology for risk contractors, specifically addressing:

Rate adjustments for case mix (including age, disability, and functional status), geographical differences in the cost of furnishing services, and the effect of outlier cases;

Alternative rate methodologies to control and reimburse for catastrophic illness;

Methods for ensuring that individuals in rural or medically underserved areas have access to quality prepaid services; and

Setting a more equitable rate for organizations which serve rural or medically underserved areas, or areas where medical practice is more conservative.

Requires the report to be prepared in consultation with HCFA and to be based in part on findings of research projects conducted by the Task Force or HCFA. The Task Force is required to allow representatives of private and prepaid health plans to comment on the report before its submission; comments are to accompany the final report submitted to Congress.

Provides that the Task Force may award research grants or contracts for assistance in its duties, provided that it demonstrates to the satisfaction of ProPAC and PPRC that the assistance is needed to provide otherwise unavailable information. The Task Force is authorized to appoint staff and establish pay rates without regard to civil service rules. Travel expenses and per diem allowances are subject to the rules for persons serving intermittently in the Government service. The Task Force is authorized to use ProPAC and PPRC staff on a reimbursable basis and with the prior consent of the commission concerned. The Task Force is permitted to use the United States mails on the same terms as other government agencies, to accept donations and volunteer services, to procure supplies, services, and property, and to make contracts. The Task Force is authorized to adopt rules and procedures, including procedures to allow interested parties to submit information.

Provides that the Task Force will terminate on January 2, 1991. Any funds held by the Task Force on that date would be returned to the Treasury and credited as miscellaneous receipts; other property would be disposed of as surplus property.

Authorizes appropriations for FY 1988 through 1991 of such sums as may be necessary to carry out the Task Force provisions.

(m) Disabled Individual Classification.—Requires the Secretary to establish a class of beneficiaries who reach age 65 during calendar 1988, 1989, 1990, or 1991, and who received Social Security disability benefits prior to reaching age 65.

(n) Two-Year Extension on Period for Benefit Stabilization.—Allows a stabilization fund to be established for a contract period beginning up to 6 years after the enactment of the Deficit Reduction Act of 1984, or July 18, 1990.

(o) Notice to enrollees.—Health maintenance organizations would be required to inform beneficiaries of the possibility that the HMO's participation in Medicare will not continue indefinitely.

Effective dates.—(a), (b), (c), (d), (g), (h), (j), (l), and (m) are effective on enactment. (i) Effective April 1, 1988, or earlier if the Secretary can provide the required data in machine readable form prior

to that date. (k) Effective on enactment. Applies to a case under chapter 11 of the Bankruptcy Code for which a plan of reorganization has not been confirmed by the court as of the date of enactment. (n) Effective as if included in the Deficit Reduction Act of 1984.

Conference agreement

(a) Broadening Use of Civil Monetary Penalties and Intermediate Sanctions against HMOs/CMPs.—The conference agreement includes the Senate amendment with a modification to provide for the higher penalty amounts included in the House provision.

(b) Capitation Demonstration Projects.—The conference agreement includes the Senate amendment, with modifications relating to demonstrations of contracts with employer related groups. The Secretary is permitted to conduct no more than three such projects, with combined expenditures to equal no more than $600 million per year, to be distributed among the projects at the Secretary's discretion. The Secretary is authorized to compute payment rates for the projects on the basis of individual average projected cost (APC) for the beneficiaries belonging to the group; rates may not exceed 95 percent of the APC. Rates may not exceed 115 percent of the AAPCC (as would be computed for a comparable arrangement with an HMO or CMP) after the third year of the project, or 95 percent of the AAPCC after the fifth year. The sponsor of the project may retain not more than 5 percent of the APC to the extent that the APC exceeds the costs of the project. At the discretion of the Secretary, additional savings would be returned to beneficiaries in the form of additional benefits or returned; no portion of the excess savings could be used to fund additional benefits for participants who are not Medicare beneficiaries.

Enrollment in the demonstration must be voluntary. Enrollees must have the right to disenroll on 30 days notice and to return to the basic Medicare and supplemental health plan coverage they had prior to enrolling. The projects would be subject to the same requirements as HMOs and CMPs with risk-sharing contracts, relating to payment of claims from outside providers, prior review of brochure and other promotional materials, review of the quality of care by a peer review organization (PRO) or other quality review organization selected by the Secretary, and civil monetary penalties for specified contractural or regulatory violations. Projects would also be required to comply with all applicable State laws.

Benefits under a project must be equal to or greater than the benefits available to enrollees under Medicare and under the employer-sponsored plan currently in effect (or equal to the actuarial equivalent of the Medicare and employer plan combined). The project must quarantee all benefits for the period of the demonstration. The project must demonstrate to the satisfaction of the Secretary that it has adequate financial reserves.

The conference agreement provides that no capitation demonstration, except one involving an eligible organization under the terms of section 1876 of the Act, may be conducted other than under the terms specified above.

The Comptoller General is required to monitor projects conducted under this section and report at least once a year to the Com-

mittee on Finance of the Senate and the Committees on Energy and Commerce and on Ways and Means of the House on the status of the projects and the effect on the projects of the requirements of this section, and to file a final report at the conclusion of the projects.

(c) Treatment of Michigan Blue Care HMO Network under 50 Percent Rule.—The conference agreement includes the Senate amendment.

(d) Assignment of HMO Members for Certain Organizations.—The conference agreement includes the Senate amendment, with an amendment to clarify that only members with a collectively bargained right to obtain services through the organization shall be considered members of the parent organization.

(e) Coverage of Social Worker Services Furnished by an HMO to Its Members.—The conference agreement includes the House provision.

(f) Delay in Effective Date of Physician Incentive Rules for Health Maintenance Organizations.—The conference agreement includes the House provision.

(g) Temporary Waiver for Watts Health Foundation.—The conference agreement includes the Senate amendment. The conferees would continue the current exemption of the Watts Health Foundation's federally qualified HMO (United Health Plan) from the 50–50 rule for Medicare risk contracts until January 1, 1990. The plan has suffered financial problems that resulted in it filing for bankruptcy under Chapter 11 of the United States Code. This further delay in the application of the 50–50 rule will provide the plan with a period in which it can reorganize and renew its efforts to enroll members who are not eligible for Medicare or Medicaid. Beginning on January 1, 1990, the plan will be required to have Secretarial approval of an enrollment schedule that will bring the plan into compliance with 50–50 rule.

(h) Extension of Waivers for Social Health Maintenance Organization.—The conference agreement includes the Senate amendment.

(i) HMO Payments for Hospital Services.—The conference agreement includes the Senate amendment, with modifications. The requirement that hospitals and skilled nursing facilities accept payment at Medicare levels as payment in full for services to risk contract enrollees applies to enrollees of all eligible organizations, rather than just those in organizations which had elected the direct payment option prior to October 1, 1987. The provision is effective for discharges on or after April 1, 1988, or, if later, on the earliest date on which the Secretary can provide the required data in machine readable form.

(j) Discount and Advance Determination of Payments.—The conference agreement does not include the Senate amendment.

(k) Post-Contract Protection for HMO and CMP Enrollees.—The conference agreement includes the Senate amendment, with modifications. The requirement applies to Federally qualified HMOs, as well as to CMPs. The organization is responsible for continued coverage for not more than 6 months after contract termination. The agreement does not include amendments to the Bankrupt Code.

1. Task Force on Medicare Capitation.—The conference agreement includes the Senate amendment, with modifications. The study of Medicare capitation is to be performed by the General Accounting Office, rather than by an independent task force. The study is to address, at a minimum: validation of the current AAPCC computation, methods for refining the AAPCC, alternatives to the use of the AAPCC in rate setting, and other issues, including problems of enrollee self-selection, catastrophic cases, and rates for rural and medically underserved areas.

(m) Disabled Individual Classification.—The conference agreement does not include the Senate amendment.

(n) Two-Year Extension on Period for Benefit Stabilization.—The conference agreement includes the Senate amendment.

(o) Notice to Enrollees.—The conference agreement includes the Senate amendment.

3. Exclusion of Direct Medical Education Costs Attributable to Training of Foreign Medical Graduates (Section 4002(b) of Senate Amendment)

Present law

COBRA requires the Secretary to pay hospitals for direct costs of graduate medical education programs (training of resident physicians) on the basis of a hospital specific, prospectively determined amount per full time equivalent (FTE) resident. The per FTE resident amount is based on the actual allowable cost per FTE resident the hospital incurred in a base year, updated to the year of payment by the rate of increase in the consumer price index. The aggregate payment the hospital receives for a cost reporting period is based on Medicare's share of the product of the hospital's per resident amount for the period multiplied by the weighted number of FTE residents the hospital had in approved medical residency training programs during the period. Medicare's share is equal to the fraction of the hospital's inpatient bed days attributable to Medicare patients.

The weighted number of FTE residents is based on certain weighting factors: residents who are in their initial residency period (years needed to qualify for board certification) are fully counted; residents not in the initial period are counted as one-half an FTE; and, after July 1, 1987, residents who are foreign medical graduates (FMGs) who have not passed a national exam are not counted at all. A foreign medical graduate is defined as a resident who is not a graduate of an accredited U.S. or Canadian school of medicine, osteopathy, dentistry, or podiatry.

House bill

No provision.

Senate amendment

Provides that, except for transition periods, foreign medical graduates (FMGs) shall not be counted in the hospital's number of FTE residents for any cost reporting period beginning on or after July 1, 1988. Under the transition rule for the first cost reporting period beginning on or after July 1, 1988, the number of FMG residents counted is equal to the lesser of: (1) two-thirds of the number of

FMG residents in approved programs during the year who began their initial period of residency training prior to July 1, 1988; or (2) two-thirds of the number of FMG residents for whom the hospital received direct medical education payments in the last cost reporting period beginning prior to July 1, 1988. For the second cost reporting period after July 1, 1988, the count is the lesser of: (1) one-third of the number of FMGs in approved programs during the year who began their initial residency period before July 1, 1988; or (2) one-third of the number of FMGs for whom the hospital received payments for direct medical education costs during the last cost reporting period beginning before July 1, 1987.

Also provides a special five year transition period for hospitals in which more than 50 percent of the residents for whom the hospital receives direct medical education payments, as of September 1, 1987, are FMGs. In this case, the first transition rule applies for the first two cost reporting periods beginning on or after July 1, 1988, and the second transition rule applies for the next three cost reporting periods.

Effective date.—Enactment.

Conference agreement

The conference ageement does not include the Senate amendment.

4. Publication of Policies (Sections 9206(j) and 9233 (b) and (d), and Section 4073 of House bill; Sections 4001(c), 4012(a), and 4081(b) of Senate amendment)

Present law

(a) Requiring Publication of Intermediary and Carrier Budget Methodology.—The Secretary is required to publish in the Federal Register the standards and criteria used to evaluate Medicare fiscal intermediaries and carriers. In paying fiscal intermediaries and carriers for their services, the Secretary is required to take into account the amount that is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated agency or organization.

Current law does not require the Secretary to publish the methodology by which he or she determines this amount.

(b) Notification of Providers of Services of Changes in Medicare Rules.—The Secretary is authorized to enter into agreements with fiscal intermediaries. These agreements require, among other requirements, that the intermediaries serve as a center for, and communicate to providers, any information or instructions furnished to the intermediary by the Secretary.

(c) Publication as Regulations of Significant Policies.—Current law requires that, except in specified circumstances, Medicare regulations must go through proposed rulemaking with a 60-day period for public comment. The law does not define a regulation for that purpose.

(d) Publication of List of Other Policies.—A number of policy matters which are issued by the Department of Health and Human Services of the Health Care Financing Administration are not required to go through public rulemaking.

(e) Advance Notice of Certain Other Policy Changes.—In addition to policies promulgated by the Department of Health and Human Services and the Health Care Financing Administration, policies are sometimes adopted by the fiscal intermediaries, carriers, or peer review organizations.

(f) Rural Impact Regulatory Analysis.—There is currently no requirement that the Secretary include, in a proposed final rule, an analysis of the regulation's impact on rural areas.

(g) No provision

(h) No provision.

(i) No provision.

House bill

(a) Requiring Publication of Intermediary and Carrier Budget Methodology.—

Section 9233(b).—Requires the Secretary to publish in the Federal Register, by September 1 before each fiscal year, the data, standards, and methodology to be used to establish budgets for fiscal intermediaries and carriers for that fiscal year.

The Secretary is first required to publish in the Federal Register for public comment, at least 90 days before, the data, standards, and methodology proposed to be used.

Section 4073.—No provision.

(b) Notification of Changes in Medicare Policy.—

Section 9233(d).—Requires each agreement between the Secretary and a fiscal intermediary to include the requirement that the intermediary transmit to each home health agency and skilled nursing facility, within 5 business days after receipt, a copy of any related coverage or program instructions and memoranda, clarifications, interpretive rules, statements of policy, and guidelines of general applicability which the Secretary has sent the intermediary. For other providers, the intermediary is required to transmit this information by the 7th day of the following month (except that the information must be sent within 5 business days if the statement is effective before the 7th day of the following month).

Section 4073.—No provision.

(c) Publication as Regulations of Significant policies.—

Section 9233.—No provision.

Section 4073.—Provides that no rule, requirement, or other statement of policy (other than a national coverage determination) that has (or may have) a significant effect on the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive Medicare services or benefits shall take effect unless it is promulgated by the Secretary by regulation.

(d) Publication of List of Other Policies.—

Section 9233.—No provision.

Section 4073.—Requires the Secretary to publish in the Federal Register, at least every 3 months, a list of all manual instructions, interpretative rules, statements of policy, and guidelines of general applicability which: (1) are promulgated by the Secretary to carry out the Medicare programs, and (2) are not published as required by (c) above or have not been previously listed as under this subsection.

(e) Advance Notice of Certain Other Policy Changes.—

Section 9233.—No provision.

Section 4073.—Provides that a carrier, fiscal intermediary, or peer review organization may not change a policy which changes (or established a standard for) Medicare payment (including the establishment of payment screens and utilization and quality control standards), unless it: (1) has a process reasonably designed to provide notice of the change to providers, practitioners likely to be affected by the change; and (2) provides notice under such a process not later than 30 days before the effective date of the change.

(f) Rural Impact Regulatory Analysis.—

Section 9206(j).—Requires the Secretary—in publishing notices of proposed and final regulations relating to Part A of Medicare—to include an analysis of the impact of such regulations on health care in rural hospitals.

Section 4073.—Requires the Secretary—in each proposed or final regulation meeting certain requirements to include an analysis of the impact of the regulation on the access of individuals to health care services in rural areas. The regulations for which this requirement applies are those that: (1) related to a Federal health care program under the jurisdiction of the Secretary; and (2) can reasonably be expected to affect a substantial number of providers of health care services in rural areas. The impact analysis is required to include an evaluation of the ability of rural health care providers to comply with any reporting requirements imposed by the regulation.

(g) Consistent and Clearly Understood Practices.—No. provision.

(h) Easily Accessible Data Base.—No provision.

(i) Report.—No provision.

Effective date.—

Section 9233(b) and (d).—(a) Applies on or after the date of enactment of this Act and applies to budgets for fiscal years beginning with fiscal year 1989. (b) Applies to any fiscal intermediary agreements as of January 1, 1988, but shall not apply to any instruction, memorandum, clarification, rule, statement, or guideline issued before that date.

Section 9206(j).—(f) Applies to regulations (and proposed regulations) issued on or after January 1, 1988.

Section 4073.—(c) Applies on or after the date of enactment of this Act, but does not apply to rules, requirements, and policies issued on or before the date of enactment of this Act. (d) Applies on or after the date of enactment of this Act, but does not apply to instructions, rules, statements, and guideline issued before January 1, 1988. The Secretary is required to first publish the required list in the Federal Register by April 1, 1988. (e) Applies to policy changes issued on or after January 1, 1988. (f)—Applies to regulations published more than 120 days after the date of enactment of this Act.

Senate amendment

(a) Requiring Publication of Intermediary and Carrier Budget Methodology.—Similar provision except that it does not contain the requirement that the Secretary, 90 days in advance, publish the data, standards, and methodologies proposed to be used.

(b) Notification of Changes in Medicare Policy.—Requires each fiscal intermediary and carrier which administers Medicare claims for extended care, post-hospital extended care, home health care, and durable medical equipment benefits to make available to the public all interpretive materials, guidelines, and clarifications of policies which relate to payments for such benefits.

(c) Publications as Regulations of Significant Policies.—No provision. [See (d) below.]

(d) Publication of List or Other Policies.—Requires the Secretary to publish in the Federal Register, not less than every three months, a list indicating the subject matter of all new home health care, extended care, post-hospital extended care, and durable medical equipment coverage instructions and clarifications that have been furnished in the preceding 3 months to fiscal intermediaries, carriers, or service providers, as well as interpretive rules, and statements of policy or policy changes, issued or used by the Secretary, and by fiscal intermediaries or carriers.

(e) Advance Notice of Certain Other Policy Changes.—Requires the Secretary to only change policies or establish standards for Medicare payment, and requires the Secretary or his or her fiscal intermediaries or carriers to only issue additional instructions, clarifications, rules, statements, and guidelines for extended care, post-hospital extended care, home health care, or durable medical equipment by written statement, made available to all affected fiscal intermediaries, carriers, and service providers (and to the Secretary when such additional statement is made by a fiscal intermediary or carrier).

Provides that any such statement shall only have effect with respect to claims submitted 30 days after its full text has been made available pursuant to (d) above.

(f) Rural Impact Regulatory Analysis.—Requires the Secretary—whenever he or she publishes a general notice of *proposed* rulemaking for any rule or regulation proposed under Medicare, Medicaid, or the peer review organization program, that may have a significant impact on substantial number of small rural hospitals—to prepare and make available for public comment an initial regulatory impact analysis.

Requires that analysis to describe the impact of the proposed rule or regulation on such hospitals and is required to set forth, with respect to small rural hospitals, the matters required under Section 603 of Title V, United States Code—to be set forth with respect to small entities.

Requires the initial regulatory impact analysis (or a summary) to be published in the Federal Register at the time of the publication of general notice of proposed rulemaking for the rule or regulation.

Requires the Secretary—whenever he or she promulgates a *final* version of a rule or regulation for which an initial regulatory impact analysis is required by the above—to prepare a final regulatory impact analysis with respect to the final version of the rule or regulation.

Requires that analysis to describe the impact of the proposed rule or regulation on such hospitals and is required to set forth, with respect to small rural hospitals, the matters required under

Section 603 of Title V, United States Code—to be set forth with respect to small entities.

Requires the Secretary to make copies of the final regulatory impact analysis available to the public and to publish, in the Federal Register at the time of publication of the final version of the rule or regulation, a statement describing how a member of the public may obtain a copy of such analysis.

Requires—if a regulatory flexibility analysis is required by Chapter 6 or Title V, United States Code, for a rule or regulation to which this subsection applies, such analysis shall specifically address the impact of the rule or regulation on small rural hospitals.

(g) Consistent and Clearly Understood Practices.—Requires the Secretary to ensure that the practices of fiscal intermediaries and carriers regarding Medicare payments are consistent with each other and, to the maximum extent possible, are clearly understood by service providers and beneficiaries.

Requires the Secretary to consult periodically with representatives of beneficiaries, service providers, fiscal intermediaries and carriers, [and] to update, and clarify, as necessary, existing policies regarding skilled nursing and home health care to meet such goals.

(h) Easily Accessible Data Base.—Requires the Secretary, to the extent feasible, to make such changes in automated data collection and retrieval by the Secretary and his or her fiscal intermediaries as are necessary to make easily accessible for the Secretary and other appropriate parties a data base which fairly and accurately reflects the provision of extended care, post-hospital extended care, and home health care Medicare benefits, including such categories as benefit denials, results of appeals, and other relevant factors, and selectable by such categories and by fiscal intermediary, service provider, and region.

(i) Report.—Requires the Secretary, not later than six months after enactment, to report to Congress on the feasibility of including in the data base required by (h) above, diagnoses (or groups of them), length of coverage, and reimbursements.

Effective date.—(a) Applies on or after the date of enactment of this Act and applies to budget for fiscal years beginning with fiscal year 1989. (b) and (d) Applies June 1, 1988. (e), (g), (h), and (i) Enactment. (f) Applies to regulations proposed more than 30 days after the date of the enactment of this Act.

Conference agreement

(a) Requiring Publication of Intermediary and Carrier Budget Methodology.—The conference agreement includes the House provision.

(b) Notification of Providers of Services of Changes in Medicare Policy.—The conference agreement includes the Senate amendment, with a modification. The intermediaries and carriers are to transmit information to providers within 30 days.

(c) Publication as Regulations of Significant Policies.—The conference agreement includes the House Provision, with an amendment to clarify that only policies establishing or changing a substantive legal standard governing benefits, payment, or eligibility must be promulgated as regulations. The conferees note that this language reflects recent court rulings.

(d) Publication of List of Other Policies.—The conference agreement includes the House provision.

(e) Advance Notice of Certain Other Policy Changes.—The conference agreement does not include either the House provision or the Senate amendment.

(f) Rural Impact Regulatory Analysis.—The conference agreement includes the Senate amendment.

(g) Consistent and Clearly Understood Practices.—The conference agreement does not include the Senate amendment.

(h) Easily Accessible Data Base.—The conference agreement includes the Senate amendment.

(i) Report.—The conference agreement includes the Senate amendment.

5. Permitting Continuation of Medicare Coverage by Payment by Individuals With Physical or Mental Impairments and Permitting Disabled To Renew Entitlement Without Waiting Period (Section 4024 of the House bill; Section 4091 of Senate amendment)

Present law

(a) Continual Hospital Insurance Benefits for Uninsured Individuals with Certain Physical or Mental Impairments.—An individual whose monthly Disability Insurance (DI) benefits cease because he or she is engaging in substantial gainful activity is entitled to HI benefits for three additional years (including 12 months worth of extended "trial work" during which DI entitlement technically continues while monthly benefits are suspended), provided the individual has not medically recovered from the impairment that established the initial entitlement to benefits.

OBRA provides that Medicare is the secondary payer for disabled Medicare beneficiaries who elect to be covered under employment-based health insurance as a current employee (or family member of such employee) of a large employer (at least 100 employees). The provision is effective 1987–1992.

(b) None.

(c) None.

(d) Buy-in to Part B Coverage.—An individual whose Disability Insurance (DI) benefits cease because he or she is engaging in substantial gainful activity is entitled to SMI benefits for three additional years, including 12 months' worth of extended "trial work" during which DI entitlement technically continues while benefits are suspended, provided the individual has not medically recovered from the impairment that established the initial entitlement to benefits.

(e) Permitting Disabled Individuals to Renew Entitlement to Medicare After Gainful Employment Without a 2-Year Waiting Period.—Individuals whose DI entitlement has been terminated must meet a two-year waiting period requirement before Medicare coverage can commence if they return to the DI rolls after 5 years (7 years in the case disabled widows and widowers and people disabled since childhood.)

House bill

(a) Continued Hospital Insurance Benefits for Uninsured Individuals With Certain Physical or Mental Impairments.—Permits a

former DI recipient, not yet age 65, who has been continuously entitled to or enrolled in HI or in a group health plan provided by the individual's employer or spouse's employer but whose entitlement to HI is about to end because of his or her engagement in substantial gainful activity, to enroll in HI if the individual's impairment continues (as re-determined annually).

Specifies that individual has no initial 7-month enrollment period beginning three months before his or her HI coverage ends.

Specifies that if the individual's enrollment or non-enrollment is unintentional, inadvertent, or erroneous and is the result of error, misrepresentation, or inaction by the Government or its instrumentalities, the Secretary may take the necessary steps to correct the situation.

Specifies that if an individual is in a group health plan (as required to be offered by an employer under conditions prescribed in Title 18 of the Act) at the time he or she is first eligible to elect enrollment for continued HI coverage, a subsequent special enrollment period can be established encompassing the 7-month period beginning with the month after the group health insurance ends. This special enrollment provision also applies to people who elect and subsequently cancel the continuation of their HI coverage provided they maintain coverage under such an employer group health plan (in effect, allowing an individual potentially to have more than one special enrollment period).

(b) Periods of New HI Coverage.—(1) Specifies periods of new HI coverage for individuals who elect continued HI coverage during their initial enrollment period, as follows—

(1) if the date of enrollment occurs before their existing HI coverage runs out, the new coverage begins in the month after the existing coverage begins in the month after the existing coverage ends;

(2) if the date of enrollment is delayed until the first month after their existing HI coverage runs out, the new coverage begins 2 months later; or

(3) if the date of enrollment is delayed until the second or later month after their existing HI coverage runs out, the new coverage begins 3 months later.

(2) Specifies periods of new HI coverage for individuals who elect continued HI coverage during a subsequent special enrollment period (as a result of having been in an employer group health plan), as follows—

(1) if the date of enrollment occurs in the month after the employer's coverage runs out, the new HI coverage would begin in that month; or

(2) if the date of enrollment occurs in a later month, the new HI coverage would begin in the month following the month of enrollment.

The new coverage would end:

(1) in the month that the individual files notice that he no longer wishes HI coverage;

(2) at the end of the grace period for nonpayment of premiums; or

(3) in the last month that the individual meets the eligibility criteria for HI coverage.

No payment would be made for expresses that were incurred outside of the coverage period.

(c) Premium.—Requires individuals to pay a monthly premium for the new HI coverage at the actuarial rate paid by aged recipients. When combined with a new SMI premium (described in (d) below), the two monthly premiums together may not exceed 8 percent of $\frac{1}{12}$th of the individual's annual gross income. However, in no case could either premium fall below 25 percent of the full premium that would otherwise be required.

Specifies that the premiums may be paid on behalf of an individual by any public or private entity under contract or other arrangement with the Secretary.

Specifies that the HI premium is to be deposited in the Treasury and credited to the HI Trust Fund.

(d) Buy-in to Part B Coverage.—Permits an individual whose SMI coverage is about to run out to enroll for continuation of such coverage in the same manner and under the same enrollment period requirements as are created for HI in the previous subsection.

Specifies that the individual is required to pay a monthly premium for the new SMI coverage at twice the actuarial rate for the aged (i.e. about four times the regular SMI premium), subject to the minimum and maximum limitations for the combined HI and SMI premiums described in (c) above.

(e) Permitting Disabled Individuals to Renew Entitlement to Medicare After Gainful Employment Without a 2-Year Waiting Period.—Permits individuals who reestablish entitlement to DI benefits after being off the rolls for 5 years (7 years in the case of disabled widows and widowers and people disabled since childhood) to be covered by the Medicare program without again having to meet the 2-year waiting period requirement. Persons may count months of a previous period of disability toward satisfying the 2-year waiting period, provided their current impairment is the same as (or directly related to) that in the previous period of disability.

Effective dates.—In general, the section would become effective for months beginning after the 60-day period beginning on the date of enactment. (a) and (b), (c) and (d) apply to individuals whose entitlement under HI would otherwise terminate after the 60-day period (e) applies when the previous period of disability ends later than 60 days after enactment.

Senate amendment

(a) Continued Hospital Insurance Benefits for Uninsured Individuals with Certain Physical or Mental Impairments.—No provision.

(b) Periods of New HI Converage.—No provision.

(c) Premium.—No provision

(d) Buy-in to Part B Coverage.—No provision.

(e) Permitting Disabled Individuals to Renew Entitlement to Medicare After Gainful Employment Without a 2-year Waiting Period.—Same as House bill.

Effective dates.—(e) applies when the previous period of disability ends later than 60 days after enactment.

Conference agreement

(a) Continued Hospital Insurance benefits for uninsured individuals with certain physical or mental impairments.—The conference agreement does not include the House provision.

(b) Periods of new HI coverage.—The conference agreement does not include the House provision.

(c) Premium.—The conference agreement does not include the House provision.

(d) Buy-in to Part B coverage.—The conference agreement does not include the House provision.

(e) Permitting disabled individuals to renew entitlement to Medicare without a 2-year waiting period.—The conference agreement includes the Senate amendment.

6. Direct Payment for Services of Registered Nurses as Assistants at Surgery (Section 4013 of House bill)

Present law

OBRA provided for direct payment for the services of physician assistants, subject to various terms, conditions and limitations on payment amounts. Among the services for which physician assistants may be reimbursed are those performed as assistants at surgery.

House bill

Provides that registered nurses may be directly reimbursed for their services as assistants at surgery under the same terms, conditions and limitations on payment amounts that apply for physician assistants. The Secretary is required to adjust payments made to hospitals to eliminate any duplicate payments that would otherwise be made as a result of this provision. The Secretary is required to report to Congress no later than April 1, 1989 concerning adjustments to payments made to physician assistants and registered nurses to assure that such payments reflect the cost of furnishing the services.

Effective date.—Applies to services rendered on or after January 1, 1988.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

7. Home Health Care Quality Improvements (Section 4031–4040 of House bill; Section 4081 (a), (c)–(j) of Senate amendment)

Present law

(a) Requirement That Individual Be Confined to Home.—To qualify for home health services, a Medicare beneficiary must be confined to his or her home under the care of a physician. In addition, the person must be in need of intermittent skilled nursing care, or physical or speech therapy. Medicare statute does not specify the criteria for meeting the "homebound" requirement. These criteria

are contained in Health Care Financing Administration program guidelines.

(b) Appeals Procedures.—(1) Fiscal intermediaries review providers claims for payments for care provided to Medicare beneficiaries and make decisions as to whether the care provided is covered care and should be paid for by Medicare. Medicare law does not require that fiscal intermediaries describe, demonstrate, or otherwise explain the reasons for denying payment for care. Nor does Medicare law require that intermediates take action on a beneficiary's appeal of a denial decision within a specified period of time.

(2) Medicare law requires the Secretary to develop standards, criteria, and procedures to evaluate a fiscal intermediary's performance of claims processing and other related functions.

Effective date.—(1) For provisions requiring the intermediary to provide a thorough explanation of a denial and to respond promptly to a reconsideration of a determination, applies to claims filed on or after Oct. 1, 1987.

(2) For provisions requiring the Secretary to use standards and criteria indicating promptness and accuracy of fiscal intermediary determinations, applies to performance of intermediaries with respect to claims filed on or after Oct. 1, 1987.

(3) Requires the Secretary to provide for such timely amendments to agreements with fiscal intermediaries and regulations to such extent as may be necessary to implement the amendments of these provisions on a timely basis.

(c) Conditions of Participation for Home Health Agencies —Establishes in Medicare statute conditions of participation for home health agencies as follows:

(1) The agency must protect and promote the rights of each individual under its care, including each of the following rights:

(a) The right to be fully informed in advance about the care and treatment to be provided by the agency; about any changes in the care or treatment to be provided; and except for an individual judged incompetent, to participate in planning care and treatment or changes in care or treatment.

(b) The right to voice grievances without discrimination or reprisal with respect to treatment or care that is or fails to be furnished.

(c) The right to confidentiality of clinical records.

(d) The right to have one's property treated with respect.

(e) The right to be fully informed orally and in writing in advance of coming under the care of the agency of items and services for which payment may be made by Medicare; coverage of items and services under Medicare, Medicaid, and any other Federal programs; any charges not covered under Medicare and any charges the individual may have to pay; and any changes in charges or items and services furnished.

(f) The right to be fully informed in writing in advance of coming under the care of the agency of the individual's rights and obligations under Medicare.

(g) The right to be informed of the availability of the State home health agency hot-line established under the bill.

(2) The agency must notify the State entity responsible for the licensing or certification of the home health agency of a change in (a) the persons with an ownership or control interest in the agency, and (b) the corporation, association, or other company responsible for the management of the agency. This notice must be given at the time of the change and must include the identity of each new person or company.

(3) The agency must not use on a fulltime, temporary, per diem, or other basis any individual who is not a licensed health care professional to provide covered home health services or items on or after Oct. 1, 1989, unless the individual (1) is competent to provide services as a result of completing a training program that meets minimum standards established by the Secretary, or (2) is enrolled in, and making timely Progress in completing a training program, and with respect to providing specific services, is competent to provide those services. The agency must also provide regular performance review and regular in-service education that assures individuals are competent to provide services. An individual would not be considered to have completed a training program if, since the individual's most recent completion of a program, there has been a continous period of 24 consecutive months during none of which the individual was used to provide services for compensation.

The Secretary would be required to establish minimum standards for training programs by not later than July 1, 1988. These standards would be required to include the content of the curriculum, minimum hours of training, qualification of instructors, and procedures for determining competency. These standards could permit recognition of programs offered by or in home health agencies, as well as other organizations (including employee organizations), and of programs in effect on the date of enactment of the bill. However, the standards could not provide for the recognition and approval of a program offered by or in a home health agency which has been determined to be out of compliance with the requirements and conditions of participation for home health agencies within the previous 2 years. Standards would be required to permit that an individual who has completed a training program before Jan. 1, 1989, be deemed to have completed a program approved by the Secretary, if the Secretary determines that at the time the program was offered, the program met the standards established as a result of this legislation.

(4) The agency must include an individual's plan of care in the person's clinical records.

(5) The agency must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations (including requirements of the Social Security Act pertaining to disclosure of ownership information) and with all accepted professional standards and principles which apply to professionals providing home health services.

Provides that it is the duty and responsibility of the Secretary to assure that the conditions of participation and requirements for home health agencies and their enforcement are adequate to protect the health and safety of individuals under the care of a home health agency and to promote the effective and efficient operation of the program.

Effective date.—Except as otherwise provided above, applies to home health agencies as of the first day of the 18th calendar month that begins after the date of enactment.

(d) Standard and Extended Survey.—(1) General Requirements for Standard Surveys.—Requires that the agreement the Secretary enters into with State or local agencies for surveying home health agencies provides that the agency conduct an annual standard survey of each home health agency. Provides that any individual who notifies, or causes to be notified, a home health agency of the time or date of this survey be subject to a civil money penalty of an amount not to exceed $2,000. Requires the Secretary to provide for imposition of the civil money penalties in a manner similar to that under current Social Security law. Requires the Secretary to review each State's procedures for scheduling and conduct of annual standard surveys to assure that the State has taken all reasonable steps to avoid giving notice of a standard survey.

(2) Frequency of Standard Surveys.—Requires that standard surveys of home health agencies be conducted without prior notice not later than 15 months after the date of the previous standard survey. Requires that the Statewide average interval between standard surveys of home health agencies not exceed 12 months. Provides that a standard survey (or an abbreviated standard survey) may be conducted within 2 months of any change of ownership, administration, or management of the agency. Requires that a standard survey be conducted with 2 months of when a significant number of complaints have been reported about a home health agency to the Secretary, the State, the licensing agency in the State, the State or local agency responsible for maintaining a toll-free hotline and investigative unit, or any other appropriate Federal, State, or local agency.

(3) Contents of Standard Survey.—Requires that the standard survey include, for a case-mix stratified sample of individuals provided services by the home health agency, visits to the homes of persons provided care, but only with the consent of such persons. Specifies that visits to the homes be for the purpose of evaluating the extent to which the quality and scope of services furnished by the agency attained and maintained the highest possible functional capacity of the individual, as reflected in the individual's written plan of care and clinical records (in accordance with a standardized reproducible assessment instrument approved by the Secretary). Also requires that the standard survey be based on a protocol that is developed, tested, and validated by the Secretary not later than Oct. 1, 1989.

(4) Conduct of Standard Survey.—Requires that the survey be conducted by an individual who meets minimum qualifications established by the Secretary not later than July 1, 1989 and who is not serving (or has not served within the previous 2 years) as a

member of the staff or as a consultant to the home health agency surveyed.

(5) Extended Survey.—Requires that each home health agency found under a standard survey to have provided substandard care be subject to an extended survey to identify policies and procedures which produced such care and to determine whether the agency has complied with the conditions of participation. Requires that the extended survey be conducted immediately after the standard survey, or, if not practical, not later than 2 weeks after the date of completion of the standard survey. Also provides that any other agency may, at the discretion of the Secretary or State, be subject to an extended or partial extended survey. Further specifies that this provision does not require an extended or partial extended survey as a prerequisite to imposing a sanction against an agency as the result of a finding of a standard survey.

(6) Assessment Instruments for Surveys.—Requires the Secretary to designate an assessment instrument or instruments not later than April 1, 1989, for use in conducting surveys. Requires the Secretary, not later than Jan. 1, 1991, to evaluate the assessment process, report to Congress on the results of the evaluation, and to make, based on the evaluation, modifications in the assessment process as appropriate. Requires the Secretary to periodically update this evaluation, report to Congress on the update, and to make additional modifications as appropriate. Further requires the Secretary to provide training of State and Federal surveyors in the use of the assessment "instrument" or instruments.

Effective date.—Except as otherwise provided, effective on the first day of the 18th calendar month to begin after the date of enactment.

(e) Enforcement.—(1) General Procedures.—Provides that if the Secretary finds that a home health agency is no longer in compliance with certification requirements and determines that the deficiencies involved immediately jeopardize the health and safety of individuals receiving care from the agency, then the Secretary must take immediate action to remove the jeopardy and correct the deficiencies by providing for temporary management or by terminating certification of the agency, and may also provide for other intermediate sanctions described below. Provides that if the deficiencies do not immediately jeopardize health and safety, the Secretary may impose for a period of not to exceed 6 months intermediate sanctions described below, in lieu of termination. Requires the Secretary to terminate certification of such an agency if, after this period of intermediate sanctions, the agency is still no longer in compliance. Also provides that if the Secretary finds that a home health agency is in compliance with the conditions of participation but, as of a previous period, did not meet the requirements, the Secretary may provide for a civil money penalty for the days the agency was not in compliance.

Provides that the Secretary may continue to make payments to home health agencies not in compliance for a period not longer than 6 months, if (1) the State or local survey agency finds that it is more appropriate to take alternative action to assure compliance than to terminate certification; (2) the agency has submitted a plan and timetable for corrective action to the Secretary and the Secre-

tary approves the plan; and (3) the agency agrees to repay Federal payments if the corrective action is not taken in accordance with the approved plan and timetable. Requires the Secretary to establish guidelines for approval of corrective actions.

(2) Intermediate Sanctions.—Requires the Secretary to develop and implement, by not later than April 1, 1989, a range of intermediate sanctions to apply to home health agencies and appropriate procedures for appealing determinations to impose such sanction. Requires that intermediate sanctions developed by the Secretary include: (1) civil money penalties (with interest) for each day of noncompliance; (2) suspension of all or part of the payments that a home health agency would otherwise be entitled to on or after the date the Secretary determines that intermediate sanctions should be imposed; and (3) the appointment of temporary management to oversee the operation of the home health agency to protect and assure the health and safety of individuals under the care of the agency while improvements are made to bring the agency into compliance. Prohibits the termination of temporary management until the Secretary has determined that the agency has the management capability to ensure continued compliance with requirements and conditions of participation.

Specifies that these intermediate sanctions are in addition to sanctions otherwise available under State of Federal law and should not be construed as limiting other remedies, including any remedy available to an individual under common law. Further provides that a finding to suspend payment shall terminate when the Secretary finds that the home health agency is in substantial compliance with all the requirements and conditions of participation.

Requires the Secretary to develop and implement, by not later than April 1, 1989, specific procedures under which each of the intermediate sanctions is to be applied, including the amount of any fines and the severity of each of the sanctions. Requires that the procedures be designed to minimize the time between identification of deficiencies and imposition of sanctions and provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies.

Effective date.—Except as otherwise provided, effective on the first day of the 18th calendar month after the date of enactment.

(f) Publication of Directory of Home Health Agencies.—Requires the Secretary to publish annually a directory containing the name, address, and telephone number of each home health agency certified to participate in Medicare. Requires the directory to provide information regarding all surveys and certifications of agencies, including information on patient care and the imposition of sanctions, if any. Requires the director to be organized by geographic area and in such a manner as to be most useful to Medicare beneficiaries. Further requires the Secretary to make the directory available to the public without charge at each district and branch office of the Social Security Administration and through area agencies on aging designated under the Older Americans Act. Requires the Secretary to promptly notify beneficiaries of the availability of any directory newly published as a result of this provision.

Effective date.—Enactment.

(g) Maintenance of Toll-Free Hotline and Investigative Unit.—Provides that the Secretary's agreement with a State or local survey agency require that agency to maintain a toll-free hotline to receive complaints and to answer questions about home health agencies in the State or locality.

Also requries the survey agency to maintain a unit for investigating complaints. Requires this unit to possess enforcement authority and to have access to survey reports.

Effective date.—Applies to agreements entered into or renewed on or after the date of enactment.

(h) Study of Adjustments to Home Health Agency Cost Limits.—Requires the Secretary to study and report to Congress, not later than Dec. 31, 1988, on (1) whether the separate schedules of cost limits currently applied to home health agencies located in urban and rural areas accurately reflect differences in costs of urban and rural home health agencies, and (2) the appropriateness of modifying such limits to take into account the proportion of agency patients who are from urban and rural areas.

Effective date.—Enactment.

(i) Data Used to Determine Home Health Agency Cost Limits.—Requires the Secretary to utilize for home health care agency cost limits a wage index that is based on data obtained from home health agencies. Also requires the Secretary to base limits on the most recent data available, which may be for cost reporting periods beginning no earlier than July 1, 1985.

Effective date.—Applies to cost reporting period beginning on or after July 1, 1988.

(j) Home Health Prospective Payment Demonstration Project.—Requires the Secretary to provide for a demonstration project to develop and test alternative methods of paying home health agencies on a prospective basis for services furnished under the Medicare and Medicaid programs. Requires the project to be designed in a manner to enable the Secretary to evaluate the effects of various methods of prospective payment (including payments on a per-visit, per-case, and per-episode basis) on program expenditures, access to and quality of home health care, and home health agency operations. Requires that the Secretary assure that services are first furnished under the project not later than July 1, 1988, and, for this purpose, authorizes the Secretary to reinstate a previously awarded contract, or to award a sole source contract to carry out the project. Requires the Secretary to submit to Congress, not later than one year after the date of enactment, an interim report on the demonstration project and, not later than 4 years after enactment, a final report on the results of the project.

Effective date.—Enactment.

(k) Moratorium on Prior Authorization for Home Health and Post-Hospital Extended Care Services.—No provision.

(l) Fiscal Intermediary Consultation Requirement.—No provision.

(m) Delay in Publishing Regulations with Respect to Deeming the Status of Home Health Agencies.—No provision.

(n) Beneficiary Notification.—No provision.

Senate amendment

(a) Requirement that Individual Be Confined to Home.—No provision. Related provision in S. 1127, the Medicare Catastrophic Loss Prevention Act of 1987.

(b) Appeals Procedures.—(1) Provides that the Secretary's agreement with a fiscal intermediary require the intermediary, for denied claims for home health services, extended care services, or post-hospital extended care services, to (a) furnish the provider and the beneficiary with a written explanation of the denial and of the statutory or regulatory basis for the denial; (b) for claims denied on the ground that the service is not medically necessary, ensure that if the beneficiary (or the provider on behalf of the beneficiary) seeks reconsideration of the denial, that the denial is reviewed by a physician (a physician with expertise in geriatrics, if available); and (c) promptly notify the beneficiary and the provider of the disposition of the reconsideration.

(2) Requires the Secretary, in evaluating the performance of fiscal intermediaries and carriers, to include in standards and criteria for home health, extended care, post-hospital extended care, and durable medical equipment claims processing, whether the intermediary is able to process 75 percent of reconsiderations within 60 days (except in the case of FY 1989, 66 percent of reconsiderations), and 90 percent of reconsiderations within 90 days, and the extent to which its determinations are reversed on appeal.

Effective date.—(1) For provisions requiring intermediary to explain denials, to use a physician to review a reconsideration, and to notify promptly, beneficiaries and providers of the disposition of a reconsideration, applies to claims received on or after Jan. 1, 1988.

(3) Similar provision, but also applies to contracts with carriers.

(c) Conditions of Participation for Home Health Agencies.—Establishes in Medicare statute similar conditions of participation for home health agencies.

(1) The agency must protect and promote the rights or each individual under its care, including each of the following rights:

(a) The right to be fully informned about care and treatment, to participate (where appropriate) in planning care and treatment, and to be fully informed in advance of any changes in care or treatment that may affect the individual's well-being.

(b) The right to voice grievances without suffering discrimination or reprisal with respect to treatment or care that is or fails to be furnished.

(c) No provision.

(d) Identical provision.

(e) Similar provision.

(f) No provision.

(g) No provision.

(2) The agency must promptly inform the State entity responsible for the licensing of the home health agency of a change in the persons with an ownership or control interest in the agency. The agency must also promptly provide the State licensing agency the name and social security account number of any individual hired by the agency to provide care and disclose whether such individual has ever been convicted of a felony.

(3) The agency must provide covered home health services (except for medical supplies and durable medical equipment) on or after Oct. 1, 1989, only through persons who are licensed health professionals or who have successfuly completed or are enrolled in and making timely progress in completing a training program that meets minimum standards established by the Secretary. Requires that the Secretary ensure that durable medical equipment suppliers are properly trained in the demonstration and use of the equipment that they supply to home health agencies.

The Secretary would be required to establish minimum standards for training programs by not later than July 1, 1988.

(4) The clinical records of an individual must include the person's plan of care.

(5) The agency must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations and with all accepted professional standards and principles.

Similar provision, but without specification of (1) "duty" of Secretary and (2) "enforcement" of conditions of participation and requirements.

Effective date.—Except as otherwise provided above, applies to home health agencies as of the first day of the 18th calendar month that begins after the date of enactment.

(d) Standard and Extended Survey.—General Requirements for Standard Surveys.—Requires that the agreement the Secretary enters into with State or local agencies for surveying home health agencies provides that the agency conduct a standard survey of each home health agency. Provides that a standard survey may be made with or without advance notice.

(2) Frequency of Standard Surveys.—Provides that standard surveys may be conducted with or without advance notice. Requires that such surveys be conducted not earlier than 9 months and not later than 15 months after the date of the most recently completed survey. Requires that a standard survey be conducted promptly upon a change of ownership of the agency or a significant number of complaints.

(3) Contents of Standard Survey.—Requires that the standard survey, not later than Jan. 1, 1990, include visits to a sample of the homes of persons provided care, but only with the consent of such persons. Specifies that visits to the home be for the purpose of evaluating the extent to which the quality and scope of services furnished by the agency improved or maintained the functional capacity of the individual (in accordance with a standardized reproducible assessment approved by the Secretary). Requires that the standard survey evaluate the quality of care and services provided and the agency's observance of the individual's rights. Also requires that the standard survey be based on a protocol that is developed, tested, and, validated by the Secretary not later than July 1, 1989.

(4) Conduct of Standard Survey.—Similar provision, except specifies that survey be conducted by an individual who has not, during the two-year period prior to the survey, served as a consultant to the home health agency surveyed with respect to their compliance with conditions of participation.

(5) Extended Survey.—Requires that each home health agency found under a standard survey to have performed poorly with

regard to compliance with any condition of participation be subject to an extended survey. Also provides that any other agency may, at the discretion of the Secretary of State, be subject to an extended survey.

(6) Assessment Instruments for Surveys.—Requires the Secretary to designate an assessment instrument or instruments not later than April 1, 1990. Identical provisions for Secretary's evaluation of assessment process, but with deadline of Jan. 1, 1992. Similar provisions for requiring Secretary to provide training of State and Federal surveyors, but without specification of training in assessment "instruments."

Effective date.—Except as otherwise provided, effective on the first day of the 18th calendar month to begin after the date of enactment.

(e) Enforcement.—(1) General Procedures.—No provisions regarding procedures to be followed when deficiencies immediately jeopardize the health and safety of individuals receiving care from an agency found to be out of compliance with certification requirements. Provides that if the Secretary finds that a home health agency no longer substantially meets the certification requirements, or, has failed to correct a deficiency according to a timetable approved by the Secretary, and furthermore determines that the deficiencies involved do not immediately jeopardize the health and safety of individuals receiving care from the agency, then the Secretary may impose for a period not to exceed one year intermediate sanctions described below, in lieu of termination.

Also requires the Secretary to develop and implement criteria and procedures for the evaluation of plans of correction submitted by home health agencies that do not meet conditions of participation and requirements. Requires that criteria and procedures be designed to maximize specificity in these plans and assure that corrections are made according to a timetable approved by the Secretary.

(2) Intermediate Sanctions.—Similar requirements for the development and implementation of intermediate sanctions, but without specification of deadline. Requires that intermediate sanctions developed by the Secretary include: (1) civil fines and penalties, and (2) suspension of all or part of the payments that a home health agency would otherwise be entitled to on or after the date the Secretary determines that intermediate sanctions should be imposed.

Specifies that these intermediate sanctions are in addition to sanctions otherwise available under State or Federal law.

Similar provision, but without specification of deadline.

Effective date.—Identical provision.

(f) Publication of Directory of Home Health Agencies.—No provision.

(g) Maintenance of Toll-Free Hotline and Investigative Unit.—Similar provision, but specifies that hotline would (1) collect, maintain, and continually update information on home health agencies in the State or localities certified to participate in Medicare (with such information required to include any significant deficiencies found with respect to patient care in the most recent certification survey conducted, when that survey was completed, whether corrective actions have been taken or are planned, and the sanctions,

if any, imposed); and (2) receive complaints and answer questions about home health agencies in the State or locality.

Similar provisions also for investigative unit, but specifies that this unit possess enforcement authority and have access to consumer medical records and survey reports.

Effective date.—Applies to agreements entered into or renewed on or after the date of enactment.

(h) Study of Adjustments to Home Health Agency Cost Limits.—Similar provision, except requires Secretary to report not later than June 1, 1988.

Effective date.—Enactment.

(i) Data Used to Determine Home Health Agency Cost Limits.—No provision.

(j) Home Health Prospective Payment Demonstration Project.—Similar provision, but requires the Secretary to conduct a study of and demonstration to test alternative methods of paying home health agencies on a prospective basis for services furnished under Medicare. Also, requires that the study and demonstration provide all necessary data for determining a prospective rate or rates for any such method and for determining whether application of a particular method allows for payment under Medicare on a budget-neutral basis.

Requires that the study account for (1) the special needs of sole community home health agencies and new home health agencies; (2) extraordinary circumstances beyond the control of home health agencies (such as significant fluctuations in population and unusual labor costs); (3) the need to minimize administrative and financial reporting requirements to reduce program costs; (4) variations in severity of illness and case complexity that cannot be adequately accounted for by the various prospective payment methods; and (5) increases in wages and the cost of goods and services included in the cost of providing home health services.

Requires that the amount paid for home health services under the demonstration be no greater than the amount that would have been paid for such services under Medicare, in the absence of the demonstration.

Requires the Secretary to submit to Congress an interim report on the progress of the demonstration not later than 12 months after the date of enactment. Also requires the Secretary, not later than July 1, 1990, to submit to Congress specific legislative proposals based on the results of the study.

Effective date.—Enactment.

(k) Moratorium on Prior Authorization for Home Health and Post-Hospital Extended Care Services.—Prohibits the Secretary from implementing any voluntary or mandatory program of prior authorization for home health services, extended care services, or post-hospital extended care services under Medicare at any time prior to 6 months after the date the Congress receives the Secretary's report and evaluation of the demonstration required under P.L. 99-509.

Effective date.—Enactment.

(l) Fiscal Intermediary Consultation Requirement.—Provides that the Secretary's agreement with a fiscal intermediary require that the intermediary implement a mechanism for consulting (at least

once annually) with representatives of home health and post-hospital extended care and extended care service providers in the region, beneficiaries of services, and appropriate personnel of the Health Care Financing Administration on problems of claims review, coverage guidelines, reconsiderations, payments, and other activities of the intermediary.

Effective date.—Effective Jan. 1, 1988. Further requires that the Secretary provide for such timely amendments to agreements with intermediaries and regulations to such extent as may be necessary to implement the amendments of this provision on a timely basis.

(m) Delay in Publishing Regulations With Respect to Deeming the Status of Home Health Agencies.—Prohibits the Secretary from publishing, earlier than 6 months after publication of proposed regulations, final regulations providing that an entity may be deemed a home health care agency for purposes of Medicare on the ground that is has been certified by a private accreditation entity.

Effective date.—Enactment.

(n) Beneficiary Notification.—Requires the Secretary, not later than 90 days after enactment of the bill, to develop and distribute to each participating provider and to each fiscal intermediary a standard form that is periodically updated (as appropriate) and contains a description of (1) rights and conditions of coverage of home health, post-hospital extended care, and extended care services furnished under Medicare; (2) rights to appeal a coverage determination where the provider of services decides not to submit a claim on behalf of the beneficiary; (3) the right to appeal (directly or through the provider) the denial of a claim; and (4) the practical steps required for initiating appeals (including sources of legal assistance). Also requires the Secretary to take appropriate steps to ensure that (1) each provider makes the standard document (as updated) available to any individual covered under Part A of Medicare at any time the individual requests home health, post-hospital extended care, or extended care services through the provider; and (2) each intermediary makes the document available to any individual receiving services at any time the intermediary makes a determination regarding home health, post-hospital extended care, or extended care services that the individual may appeal.

Effective date.—Enactment.

Conference agreement

(a) Requirement That Individual Be Confined to Home.—The conference agreement includes the House provision, with an amendment to provide that the limitations on individual's absences from home do not apply to absences for the purpose of medical treatment.

(b) Appeals Procedures.—The conference agreement includes the Senate amendment to apply the same appeals procedures to all claims for home health services under Part B and to all claims for services under Part A, except inpatient hospital services. The conference agreement does not include the requirement for physician reviews of medical reconsiderations. The conferees understand that administrative law judges may or may not base their decisions on criteria beyond those used by fiscal intermediaries. Thus, in setting

the standards under this subsection, the Secretary shall take this understanding into account.

(c) Conditions of Participation for Home Health Agencies.—The conference agreement includes the House provision, with an amendment to provide that DME suppliers must not use on a full-time, temporary, per diem, or other basis any individual who does not meet minimum training standards for the demonstration and use of the equipment that they supply to individuals entitled to Medicare benefits. The Secretary is required to establish the minimum training standards by October 1, 1988. The resident assessment requirement is deferred one year.

(d) Standard and Extended Survey.—The conference agreement includes the House provision, with two amendments. The sample of persons provided care to be visited at home is required to be a case-mix stratified sample to the extent practicable. The deadline for the Secretary's evaluation of the assessment instrument is changed to January 1, 1992.

(e) Enforcement.—The conference agreement includes the House provision.

(f) Publication of Directory of Home Health Agencies.—The conference agreement does not include the House provision.

(g) Maintenance of Toll-Free Hotline and Investigative Unit.—The conference agreement includes the Senate amendment, with a modification to clarify that the investigative unit shall have access to survey and certification records and to consumer medical records but only with the consent of the consumer or his/her legal representatives.

(h) Study of Adjustments to Home and Health Agency Cost Limits.—The conference agreements includes the Senate amendment.

(i) Data Used to Determine Home Health Agency Cost Limits.—The conference agreement includes the House provision, with an amendment to require that only audited wage date obtained from home health agencies be used in the development of the wage index.

(j) Home Health Prospective Payment Demonstration Projects.—The conference agreement includes the House provision.

(k) Moratorium on Prior Authorization for Home Health and Post-Hospital Extended Care Services.—The conference agreement includes the Senate amendment.

(l) Fiscal Intermediary Consultation Requirement.—The conference agreement does not include the Senate amendment.

(m) Delay in Publishing Regulations with Respect to Deeming the Status of Home Health Agencies.—The conference agreement includes the Senate amendment with an amendment to include the deeming of all providers.

(n) Beneficiary Notification.—The conference agreement does not include the Senate amendment.

ESRD Amendments (Sections 4077, 4078, and 4081 of House bill; Section 4013(b) of Senate amendment).

Present law

(a) Implementation of Primary Payer Requirements for ESRD Program.—Medicare law sets forth certain circumstances under which

Medicare payments become secondary to payments from other sources; such as other insurance coverage or workmen's compensation.

Medicare benefits are secondary for a limited period of time (up to 12 consecutive months) in the case of individuals who are entitled to Medicare solely on the basis of end-stage renal disease and who are entitled to coverage under an employer group health plan. During the period in which Medicare is secondary, Medicare pays primary benefits for Medicare-covered services not covered under the employer plan and makes secondary payments to supplement the amount paid by the employer plan if that plan pays only a portion of the charge.

In general, the secondary payer provisions specify that Medicare payment may not be made if payment has been made or can reasonably be expected to be made by the other payer. However, in the case of end-stage renal disease beneficiaries, the standard is whether payment has been made or will be made as promptly as would be made by Medicare.

(b) Limitation of Minimum Utilization Rate Requirement for ESRD Transplantations.—In order to qualify for Medicare payments for covered services to end-stage renal disease patients, providers must meet requirements for a minimum utilization rate for covered procedures and for self-dialysis training programs. Covered services currently include dialysis, dialysis training, and transplantation.

(c) Studies of ESRD Program.—The Secretary is currently required to submit an annual report on the end-stage renal disease program to Congress by July 1 of each year.

House bill

(a) Implementation of Primary Payer Requirements for ESRD Program.—Conforms the payment standard for ESRD payments to that applicable under other secondary payer provisions.

(b) Limitation of Minimum Utilization Rate Requirement for ESRD Transplantations.—Provides that the minimum utilization requirements will only apply to transplantation.

(c) Studies of ESRD Program.—(1) *In General.*—Requires the Secretary to arrange for a study of the end-stage renal disease program.

(2) Items Included in Study.—Requires the study to address, among other items: (A) access to treatment by both Medicare beneficiaries and other patients; (B) the quality of care provided to end-stage renal disease beneficiaries, as measured by clinical indicators, functional status of patients, and patient satisfaction; (C) the effect of reimbursement on qualify of treatment; (D) major epidemiological and demographic changes in the end-stage renal disease population that may affect access to treatment, the quality of care, or the resource requirements of the program; and (E) the adequacy of existing of data systems to monitor these matters on a continuing basis.

(3) Report.—Requires the Secretary to submit to Congress, by 3 years after the date of enactment of this Act, a report on the study.

(4) Arrangements for the Study.—Requires the Secretary to request the National Academy of Sciences, acting through the Insti-

tute of Medicine, to submit an application to conduct the required study. If the Academy submits an acceptable application, the Secretary shall enter into an appropriate arrangement with the Academy for the conduct of the study. If the Academy does not submit an acceptable application, the Secretary may request one or more appropriate nonprofit private entities to submit an application to conduct the study and may enter into an appropriate arrangement for the conduct of the study by the entity which submits the best acceptable application.

(5) Elimination of Unneeded Reporting Requirements.—Eliminates the current requirement that the Secretary may submit an annual report on the end-stage renal disease program to Congress by July 1 of each year.

Effective date.—(a) Applies with respect to items and services furnished on or after 30 days after the date of enactment. (b) and (c) Enactment.

Senate amendment

(a) Implementation of Primary Payer Requirements for ESRD Program.—Similar provision.

(b) Limitation of Minimum Utilization Rate Requirement for ESRD Transplantations.—No provision.

(c) Studies of ESRD Program.—No provision.

Effective date.—(a) Enactment.

Conference agreement

(a) Implementation of Primary Payer Requirements for ESRD Program.—The conference agreement includes the House provision.

(b) Limitation of Minimum Utilization Rate Requirement for ESRD Transplantations.—The conference agreement includes the House provision with a modification to extend to July 1, 1988 the date by which guidelines concerning the reuse of bloodlines would be required (Current law requires the guidelines by January 1, 1988).

(c) Studies of ESRD Program.—The conference agreement includes the House provision. The conferees note that this provision should not be interpreted as implying that the Congress will not make modifications to the program prior to receiving the required report.

9. Certification of Pediatric Heart Transplant Program (Section 4085 and Section 9206(g) of House bill)

Present law

Under current law, the Secretary certifies cardiac transplant centers for Medicare participation and for Medicare reimbursement for transplant services. Under current regulations, no pediatric centers are certified.

House bill

Section 4085.—Requires the Secretary to review, upon the request of a pediatric heart transplant center, whether or not the center meets the standards and criteria for qualification as a Medicare heart tranplant center, other than the standards and criteria regarding the minimum number of heart transplants per year. If

the Secretary determines that the center meets the standards and criteria (other than for the number of heart transplants performed), the Secretary is required to issue a certification of its qualifications.

Section 9206(g).—Requires the Secretary to determine that a pediatric hospital meets the criteria of a Medicare heart transplant facility if: (1) the hospital's pediatric heart transplant program is operated jointly by the hospital and another facility that meets such criteria; (2) the unified program shares the same transplant surgeons and quality assurance program (including oversight commitee, patient protocol, and patient selection criteria); and (3) the hospital demonstrates to the satisfaction of the Secretary that it is able to provide the specialized facilities, services, and personnel that are required by pediatric heart transplant patients.

Effective date.—

Section 4085.—Applies on or after the date of enactment of this Act.

Section 9206(g).—Applies on or after the date of enactment of this Act.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision in section 4085. (The House provision included a section 9206(g) is included in the agreement—see discussion of Part A).

10. Medicare Contractors (Sections 4012 (b) and (c) of Senate Amendment)

Present law

(a) Payment Safeguards.—The Secretary contracts with fiscal intermediaries and carriers to determine and make payments for Medicare benefits and to perform audits and other related functions.

The Consolidated Omnibus Budget Reconciliation Act of 1985 earmarked $105 million for FY 1986, FR 1987, and FY 1988, for the exclusive purposes of conducting provider cost audits, medical necessity reviews, and the recovery of third-party liability payments.

(b) Prohibition Against Denial Quotas.—The Secretary develops standards and criteria for evaluating the performance of Medicare fiscal intermediaries and carriers. There are currently no statutory requirements specifically relating to criteria related to denial quotas.

(c) Authority of the Secretary.—The Secretary currently has authority to (1) ascertain the accuracy of decisions (including Medical review decisions) made by a fiscal intermediary or a carrier, and (2) prescribe standards for measuring the performance of any such fiscal intermediary or carrier.

House bill

(a) Payment Safeguards.—No provision.

(b) Prohibition Against Denial Quotas.—No provision.

(c) Authority of the Secretary.—No provision.

Senate amendment

(a) Payment Safeguards.—Increases the amount for these activities by $100 million for FY 1988, FY 1989, and FY 1990.

(b) Prohibition Against Denial Quotas.—Prohibits the Secretary, when establishing standards and criteria for fiscal intermediaries and carriers, from evaluating them solely on the basis of any specified numerical ratio of (1) amounts that must be saved through denial of claims under utilization review to (2) amounts expended with respect to such review.

(c) Authority of the Secretary.—Provides that nothing in (a) or (b) above shall be construed to limit the authority of the Secretary, under the law in effect on the date of the enactment of this Act, to (1) ascertain the accuracy of decisions (including Medical review decisions) made by a fiscal intermediary or a carrier. (2) prescribe standards for measuring the performance of any such fiscal intermediary or carrier, and (3) refuse renewal of (or renew conditionally) any such fiscal intermediary agreement or carrier contract for failing to meet such standards.

Effective date.—(a) Applies with respect to fiscal years beginning with FY 1988. (b) and (c) Enactment.

Conference agreement

The conference agreement does not include the Senate amendments.

11. Secondary Payer Provisions (Section 4013(a) of Senate Amendment)

Present law

The Omnibus Budget Reconciliation Act of 1986 provides that Medicare is the secondary payer in the case of disabled Medicare beneficiaries who also had group health insurance through their employer or their spouse's employer. This provision applies to employers who have 100 or more employees.

House bill

No provision.

Senate amendment

Clarifies that this provision applies to government entities, but specifies that the tax penalty does not apply to government entities.

Effective date.—Applies on or after January 1, 1987.

Conference agreement

The conference agreement includes the Senate amendment.

12. Hearings and Appeals (Section 4089 of Senate amendment)

Present law

The Omnibus Budget Reconciliation Act of 1986 established administrative and judicial review procedures for Medicare's Part B. These procedures are comparable to those previously in effect for Part A.

Administrative review has been handled by administrative law judges within the Social Security Administration of the Department of Health and Human Services.

House bill

(a) Maintaining Current System for Hearings and Appeals.—No provision.

(b) Study and Report on Use of Telephone Hearings.—No provision.

Senate amendment

(a) Maintaining Current System for Hearings and Appeals.—Requires any Part A or Part B administrative review hearing before the date on which the Secretary submits the report required in (b) below to be conducted by administrative law judges of the Office of Hearings and Appeals of the Social Security Administration in the same manner as hearings are conducted under Section 205(b)(1) of the Social Security Act.

(b) Study and Report on Use of Telephone Hearings.—Requires the Secretary, together with the Comptroller General to conduct a study on holding Part A and Part B administrative review hearings by telephone and to report the results of the study by 6 months after enactment.

Requires that study to focus on whether telephone hearings allow for a full and fair evidentiary hearing, in general, or with respect to any particular category of claims and to examine the possible improvements to the hearing process (such as cost-effectiveness, convenience to the claimant, and reduction in time under the process) resulting from the use of such hearings as compared to the adoption of other changes to the process (such as expansions in staff and resources).

Effective date.—Enactment.

Conference agreement

(a) Maintaining Current System for Hearings and Appeals.—The conference agreement includes the Senate amendment, with a modification. The requirement that hearings be conducted by administrative law judges of the Social Security Administration continues in effect until the earlier of September 1, 1988, or the date the Secretary files the report required by (b), below.

(b) Study and Report on the Use of Telephone Hearings.—The conference agreement includes the Senate amendment.

13. Rural Health Medical Education Demonstration Projects (Section 4002(c) of Senate amendment)

Present law

No provision.

House bill

No provision.

Senate amendment

Requires the Secretary to enter into agreements, within six months after enactment, with four sponsoring teaching hospitals to

conduct three year demonstration projects to assist resident physicians to obtain field clinical experience in rural areas. Each sponsoring hospital is required to enter into an arrangement to provide a small rural hospital with physicians, who have completed one year of residency training, for periods of one to three months.

In selecting applications from potential sponsoring hospitals, the Secretary is required to ensure that four small rural hospitals located in different counties participate. Two of these must be located in rural counties of more than 2,700 square miles, and two must be located in rural counties that have a severe shortage of physicians; one of each type of hospital must be located east and one west of the Mississippi River.

For purposes of determining the amount of additional payments under PPS for indirect costs of graduate medical education activity (the teaching adjustment), residents who participate during any part of a year, are counted as if they worked at the sponsoring hospital on September 1 of that year, and not counted as if working at the small rural hospital.

For purposes of determining the amount of payment for the direct costs of graduate medical education activities in a sponsoring hospital, the amount otherwise permitted under current law is increased by an amount equal to the amount of direct costs the hospital incurs in supervising the training activities of the demonstration project.

Effective date: Enactment.

Conference agreement

The conference agreement includes the Senate amendment.

14. Nurse Services (Section 4131 and 4132 of Senate Amendment)

Present law

(a) Certification and Recertification of the Need for Certain Services.—Under the current Medicare law, specific conditions and limitations are placed on Medicare reimbursement for services. For post-hospital extended care services, the law provides that a physician certify and recertify that such services are required as a condition for Medicare reimbursement.

(b) Coverage of Certain Items and Services Furnished by a Nurse Practitioner or Clinical Nurse Specialist.—No provision.

House bill

No provision.

Senate amendment

(a) Certification and Recertification of the Need for Certain Services.—Amends the provision of the Medicare law relating to certification and recertification by a physician (as a condition of and limitation for payments of Medicare services) to provide for certification by a physician, or in the case of post-hospital extended services, by a physician or a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician. Amends also the section of the Medicare law that defines a skilled nursing facility. Provides that where it currently specifies that the health care of every patient be under

the supervision of a physician, that it now specify that the patient be under the supervision of a physician or a nurse practitioner or clinical nurse specialist working in collaboration with a physician. Provides that where it currently specifies that a physician be available to furnish emergency care that it now specify a physician or a nurse practitioner or clinical nurse specialist working in collaboration with a physician be available to furnish such care.

Provides for a definition of nurse practitioner and clinical nurse specialist. Specifies that an individual shall be treated as a nurse practitioner or clinical nurse specialist if the individual (1) is licensed to practice professional nursing; (2) performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law); and (3) (A) is master's prepared in nursing; or (B) holds a masters degree in a related field and is certified or certified eligible by a national organization; or (C) has completed a nurse practitioner continuing education program and is certified or certified eligible.

Provides that a nurse practitioner or clinical specialist works in collaboration with a physician where the nurse and physician act pursuant to an agreement that allocates responsibility for decisions and actions, but allows each professional to retain responsibility for their respective actions and engage in such actions independently.

Makes other conforming changes in definitions in the Medicare statute.

(b) Coverage of Certain Items and Services Furnished by a Nurse Practitioner or Clinical Nurse Specialist.—Amends the provision of Medicare law relating to payment of benefits to provide that, with respect to items and services furnished by a nurse practitioner or clinical nurse specialist in a skilled nursing facility and services and supplies furnished as an incident to such services, that the amount paid be equal to 100 percent of the amount determined as the reasonable charge for such items and services under as determined under section 1824(b) (10) (sic). Provides that in providing for the items and services described above that each carrier shall require that payment be made on the basis of assignment, except that the reasonable charge shall be determined as 75 percent of the prevailing charge paid for similar items and services provided by physicians in the same locality.

Provides for technical and conforming changes in the Medicare statute.

Effective date.—Applies to items and services furnished on or after the date of enactment.

Conference Agreement

The conference agreement does not include the Senate amendments.

15. Miscellaneous and Techincal Provisions Relating to Parts A and B (Section 9204, Sections 9233 (a), (c), (e), and (f), Section 4076 of the House bill; Section 4087 and 3093 of Senate amendment)

Present law

(a) Clarification of Criminal Penalties for Willful Misrepresentations.—Medicare law currently makes it a felony and permits fines

of up to $25,000 or jail terms of up to 5 years for officers of a hospital, skilled nursing facility, or home health agency who falsify conditions of operation of the facility in order to qualify or continue to qualify for payment from Medicare.

Before P.L. 100-93 Medicare law did not include officers of other entities which participate in Medicare among those who are subject to criminal sanctions. However P.L. 100-93 includes officers of other entities.

(b) Extend and Clarify Prohibition on Cost Savings Policies Before Beginning of Fiscal Year.—The Secretary is prohibited from issuing any regulation, instruction, or other policy in final form prior to September 1, 1987 which is estimated by the Secretary to result in a net reduction in expenditures during FY 1988 of more than $50 million for hospital or physician services provided under Medicare.

(c) Podiatrists.—(1) Definition as Physicians.—Podiatrists are defined as physicians with respect to the funtions which they are legally authorized to perform under the laws of the State in which they practice but only if such practice is consistent with the policy of the institution or agency in which the services are provided.

(2) Accrediting Organization.—Medicare law refers to interns and residents that are in teaching programs approved by various certifying organiations. One of these is the Council on Podiatry Education of the American Podiatry Association. In 1984, the name of this organization was changed to the Council on Podiatric Medical Education of the American Podiatric Medical Association.

(d) Recovery of Payments for Certain Pacemaker Devices.—The Secretary is required, through the Commissioner of the Food and Drug Administration, to provide for a registry of all cardiac pacemaker devices and leads for which payment has been made under Medicare. Such registry is to include information on the device, date of implantation, express or implied warranties under contract or State law, and certain other information that would assist the Secretary in determining when payments may properly be made under Medicare. Physicians and providers are required to submit information to the registry.

The Secretary may require, by regulation, that providers return to manufacturers those devices and leads removed from patients whose implantation was paid for under Medicare, and that they not charge beneficiaries for replacement if the device or lead is not returned to the manufacturer for testing.

The Secretary may deny payments under Medicare for implantation and replacement if: (1) the physician or provider has failed to submit information to the registry, (2) the provider has failed to return devices removed to the manufacturer, or (3) if the manufacturer has failed to perform and report on the testing of returned devices.

(e) Technical Part A and B Amendments.—Current law contains a number of technical errors.

House bill

(a) Clarification of Criminal Penalties for Willful Misrepresentations.—

Section 9233(a).—Clarifies that officers of other entities (including health maintenance organizations and competitive medical plans) are officers who would be held criminally liable for willful misrepresentations in an attempt to qaualify for Medicare payments.

Section 4076.—No provision.

Effective date.—

Section 9233(a).—Applies on or after the date of enactment of this Act.

(b) Extend and Clarify Prohibition of Cost Savings Policies Before Beginning of Fiscal Year.—

Section 9233(c).—Prohibits the Secretary from issuing any regulation, instruction, or other policy in final form before October 15, 1988 which is estimated by the Secretary to result in a net reduction in Medicare expenditures in FY 1989 of more than $50 million.

Section 4076.— No provision.

Effective date.—

Section 9233(c).—Enactment.

(c) Podiatrists.—

(1) Definition as Physicians.—

Section 9233(e).—Defines podiatrists as physicians with respect to the functions which they are legally authorized to perform under State laws.

Section 4076.—Similar provision.

(2) Accrediting Organization.—

Section 9233(e).—Changes reference to the Council *on* Podiatric Medical Education of the American Podiatric Medical Association.

Section 4076.—Similar provision.

Effective date.—

Section 9233(e).—Enactment.

Section 4076.—Enactment.

(d) Recovery of Payments for Certain Pacemaker Devices.—No provision.

(e) Technical Part A and B Amendments.—

Section 9233(f).—Corrects technical errors.

Section 4076—No provision.

Effective date.—

Section 9233(f).—Applies on or after the date of enactment of this Act.

Senate amendment

(a) Clarification of Criminal Penalties for Willful Misrepresentations.—No provision.

(b) Extend and Clarify Prohibition on Cost Savings Policies Before Beginning of Fiscal Year.—No provision

(c) Podiatrists.—

(1) Definition as Physicians.—No Provision.

(2) Accrediting Organization.—Similar provision, although it refers to the Council of Podiatric Medical Education of the American Podiatric Medical Association.

Effective date.—Enactment.

(d) Recovery of Payments for Certain Pacemaker Devices.—Requires that information reported to the registry include any amounts paid to providers under an express or implied warranty under contract or State law. The Secretary may require that pro-

viders make repayments to the Secretary with respect to any cardiac pacemaker device or lead which has been replaced by the manufacturer or for which the manufacturer has made payment to the provider under an express or implied warranty. The Secretary may deny payments to providers with respect to the implantation or replacement of pacemaker devices or leads if the provider fails to make required repayments to the Secretary.

Effective date.—January 1, 1988.

(e) Technical Part A and B Amendments.—No provision.

Conference Agreement

(a) Clarification of Criminal Penalties for Willful Misrepresentations.—The conference agreement includes the House provision.

(b) Extend and Clarify Prohibition on Cost Savings Policies Before Beginning of Fiscal Year.—The conference agreement includes the House provision.

(c) Podiatrists.—The conference agreement includes the House provision. The conferees desire to clarify that podiatrists are authorized to serve on utilization review committees.

(d) Recovery of Payments for Certain Pacemaker Devices.—The conference agreement includes the Senate amendment.

(e) Technical Part A and B Amendments—The conference agreement includes the House provision.

C. Medicare Provisions (Part B)

1. Physician Payment Update (Sections 9261, 4003, and 4004 of House bill: Sections 4021 (a) and (b) of Senate amendment.

Present law

Payments are made to physicians on the basis of reasonable charges. The reasonable charge for a service is the lowest of the physician's actual charge, the physician's customary charge, or the prevailing charge for the service in the community. Annual increases in prevailing charges are limited by the Medicare Economic Index (MEI) which reflects yearly increases in overhead costs for physicians and general changes in earnings levels. The MEI was set by Congress at 3.2% in 1987. HCFA has announced an MEI increase of 3.6% for 1988.

Payments for physicians' services are made on an assigned or unassigned basis. If assignment is accepted, the physician agrees to accept Medicare's determination of the reasonable charge as payment in full for covered services. On assigned claims, beneficiary liability is limited to the 20% coinsurance (after the deductible has been met). In the case of nonassigned claims, physicians may "balance bill" the patient for the difference between Medicare's reasonable charge and the physician's actual charge.

Physicians who agree to accept assignment on all claims for the forthcoming year are known as participating physicians. The prevailing charge limit for nonparticipating physicians is set at 96% of that for participating physicians. Nonparticipating physicians are subject to a limit on their actual charges known as Maximum Allowable Actual Charges (MAACs).

OBRA (1986) authorized bonuses by April 1, 1988, to carriers for their success in increasing the proportion of participating physicians during the enrollment period at the end of 1987.

House bill

(a) Three-Month Freeze on Increases in Physician Payments.—No provision.

(b) Payment Update.—

Section 9261.—Specifies a 2% increase in the MEI in 1988 for participating physicians.

Sets the prevailing charge limit for nonparticipating physicians at 95% of that for participating physicians. As a result, the increase for nonparticipating physicians in 1988 is approximately 1%.

Section 4003.—Specifies that the MEI increase in 1987 is 3.2%.

Specifies that the MEI increase for 1988 is 6% for primary care services and 2% for other physicians services. Primary care services are defined as physicians services which constitute immunization injections: office medical services; home medical services; skilled nursing, intermediate care, and long-term care medical services; or nursing home, boarding home, domiciliary, or custodial care medical services (as defined in procedure code by the Secretary).

(c) Incentive Payments for Primary Care Physicians in Underserved Rural Areas.—

Section 9261.—No provision.

Section 4004.—Specifies that in the case of services furnished by a primary care physician in a rural area. Part B payments otherwise made are to be increased by 10% of the prevailing charge. Incentive payments are made on a monthly or quarterly basis.

Defines a primary care physician as one whose primary practice of medicine is in the field of family practice, general practice, general internal medicine, gynecology, or pediatrics. A rural area is defined as one which is a class 1 or class 2, rural, primary medical care health manpower shortage area as designated by the Secretary under Section 332 of the Public Health Service Act.

Requires the Secretary to study and report to the Congress by July 1, 1988 on the feasibility of making such additional payments for urban underserved areas.

Effective date.—

Section 9261—Applies to services furnished on or after January 1, 1988.

Section 4003.—Enactment.

Section 4004.—Applies to services performed on or after April 1, 1988.

Senate amendment

(a) Three-Month Freeze on Increases in Physician Payments.—Holds the prevailing and customary charges for physicians' services furnished during the three-month period beginning January 1, 1988 at the 1987 levels. Through January 15, 1988, the benefit payments would also reflect the sequestration reductions as required under Section 4014 of this Act.

Specifies that the MAACs for nonparticipating physicians for the three-month period beginning January 1, 1988, are the same as those determined for 1987. The MAAC otherwise determined for 1988 takes effect April 1, 1988.

Specifies that: (1) agreements with participating physicians in effect on December 31, 1987 remain in effect for the three month period beginning January 1, 1988, unless the physician requests that it be terminated; and (2) agreements entered into for 1988 are effective for the nine month period beginning April 1, 1988.

Modifies the OBRA (86) carrier bonus provision by specifying that such payments are to be made by July 1, 1988, for the enrollment period prior to April 1, 1988.

(b) Payment Update.—Specifies that the MEI increase for services furnished in 1988 after April 1, 1988 is the full amount of the percentage increase in the MEI for primary services and 0% for other physician's services. The definition of primary care services is similar to that in Section 4003, except that immunization injections are not included and emergency department visits are added.

(c) Incentive Payments for Services in Underserved Rural Areas.—Provides for incentive payments in the case of physician services furnished on an assignment-related basis in a rural area (as defined under PPS) which is designated as a health manpower shortage area under the PHS Act. Part B payments otherwise made are to be increased by 5%. Incentive payments are made on a monthly or quarterly basis.

Effective date.—(a) and (b) Enactment. (c) Applies with respect to services furnished on or after April 1, 1989.

Conference agreement

(a) *Three-Month Freeze on Increases in Physician Payments.*—The conference agreement includes the Senate amendment.

(b) *Payment Update.*—The conference agreement includes the Senate amendment with a modification. The agreement provides that for the nine month period beginning April 1, 1988, the increase in the MEI for participating physicians is 3.6 percent for primary care services, and 1.0 percent for other services. For nonparticipating physicians, the increase is 3.1 percent for primary care services and 0.5 percent for other services.

For physicians' services furnished in 1989, the percentage increase for participating physicians is 3.0 percent for primary care services and 1.0 percent for other services. For nonparticipating physicians, the increase is 2.5 percent for primary care services and 0.5 percent for other services.

The cumulative effect of the 0.5 percent differentials for participating physicians in each year is to increase the existing 4 percent payment differential for participating physicians to a total of 5 percent.

The Conference agreement adopts the Senate definition of primary care which represents the following categories of visits and current HCPCS procedure codes: office visits (90000 through 90080); home visits (90100 through 90170); skilled nursing, intermediate care and long-term care facility visits (90300 through 90370); nursing home, boarding home, domiciliary or custodial care medical visits (90400 through 90470); and emergency department visits

(90500 through 90570). The Conferees note specifically that the higher MEI is intended to apply to the visits but not to any separate billable services that are done in conjunction with such visits.

(c) *Incentive Payments for Physicians for Services in Underserved Rural Areas.*—The conference agreement includes the Senate amendment with an amendment. The agreement specifies that the incentive payments are limited to primary care services furnished by all physicians in an area (as defined in PPS) or a class 1 or class 2 health manpower shortage area. The bonus payments, which equal 5 percent of the allowed payment amounts, will apply with respect to services furnished in rural areas on or after January 1, 1989 and to other services on or after January 1, 1991.

The conference agreement also includes the study contained in the Energy and Commerce provision regarding the feasibility of making bonus payments to physicians located in urban health manpower shortage areas. The report is due by January 1, 1990.

2. Reduction of Payments for Certain Procedures (Sections 9262 and 4001 of House bill: Section 4021(d) of Senate amendment)

Present law

(a) Payment Reductions.—OBRA specified that the maximum allowable prevailing charges, otherwise recognized for participating and nonparticipating physicians performing cataract surgical procedures, are reduced by 10% with respect to procedures performed in 1987 and 2% with respect to procedures performed in 1988. In no case can the reduction for a surgical procedure result in a prevailing charge that is less than 75% of the weighted national average of such prevailing charges for such procedure for all localities in the U.S. in 1986.

The law authorizes the Secretary, under the so-called "inherent reasonableness" authority to establish payment limits based on considerations other than actual, customary or prevailing charges. The law specifies the circumstances under which a departure from the standard is appropriate.

Actual Charge Limit.—The law establishes maximum allowable actual charges (MAAC) for nonparticipating physicians. If an adjustment is made in payments for cataract surgery, a special limit is applied for actual charges of nonparticipating physicians. In the first year, the limit is 125% of the reduced prevailing charge plus one-half of the difference between the physician's actual charge in the preceding period and the 125% amount. In the second year the limit is 125% of the reduced prevailing charge. Sanctions may be imposed if a physician knowingly and willfully violates the limits. Similar limits apply with respect to physicians supervising nurse anesthetists, cataract surgery anesthesia, and payment reductions under the Secretary's inherent reasonableness authority.

House bill

(a) Payment Reductions.—

Section 9262.—Replaces the 2% reduction for cataract surgery scheduled for 1988 with a reduction equal to 15% over the amount recognized in 1987. The prevailing charges for additional specified procedures are to be reduced by 15% over the amount recognized in 1987. The procedures are: contrary artery bypass, total hip re-

placement, transurethral resection of the prostate, suprapubic prostatectomy, diagnostic and therapeutic dilation and curettage, and carpal tunnel repair.

Sets the floor at 80% of the weighted national average prevailing charge for the procedure in 1987. Judicial review of this determination is prohibited.

Section 4001.—Replaces the 2% reduction for cataract surgery scheduled for 1988 with a reduction equal to 5% over the amount recognized in 1987. For other specified procedures, the reduction is equal to 10% over the amount recognized for 1987. The specified procedures are the same as those in Section 9361, except that therapeutic dilation and curettage is not included.

Specifies that the prevailing charge in a carrier locality is further reduced by an additional amount equal to 10% of the amount by which the prevailing charge for the locality (after the across-the-board reduction) exceeds the weighted average of prevailing charges in the region in which the locality is situated. The same regions are to be used as are designated for PPS.

Specifies that in no case can the reduction result in a prevailing charge that is lower than 80% of the weighted national average of such prevailing charges for such procedures in all localities in 1987.

(b) Actual Charge Limit.—

Section 9262.—Specifies that the special limits for cataract surgery and other procedures identified under (a) above are set as follows:

(i) in the first year, 125% of the reduced prevailing charge plus one-half of the difference between the 125% level and the previous year's MAAC.

(ii) in the second year, 125% of the reduced prevailing charge; and

(iii) during any subsequent year, 115% of the reduced prevailing charge.

Specifies that limits do not apply to items and services furnished after the earlier of December 31, 1990 or one year after the date of the Secretary reports to Congress on the development of a relative value scale.

Provides that the special limits also apply with respect to payment reductions under the Secretary's inherent reasonableness authority, physicians supervising nurse anesthetists, and cataract surgery anesthesia.

Specifies that sanctions may be imposed for violations of these limits (whether or not there are also violations of the MAAC limits).

Section 4001.—Similar provision except: (i) the limit remains at 125% in the third and subsequent years; (ii) no modification is made in the other special limits; and (iii) no reference is made to MAAC violations in the sanctions provision.

Effective date.—

Section 9262.—Applies to items and services furnished on or after January 1, 1988, with respect to the 80% floor for cataracts and for purposes of the cataract anesthesia reductions, the special limits shall not apply for the first 12-month period and the reference to the following 12-month period is deemed a reference to 1988.

Section 4001.—Applies to procedures performed on or after January 1, 1988.

Senate amendment

(a) Payment Reductions.—Reduces prevailing charges for specified procedures performed in 1988 according to the following percentages:

(1) 15% in the case of a prevailing charge that is at least 150% of the weighted national average (as determined by the Secretary) of prevailing charge for such procedure for all localities in the U.S.

(2) 0% in the case of a prevailing charge that does not exceed 100% of such average; and

(3) A percentage between 0% and 15% determined on the basis of a straight-line sliding scale (as determined by the Secretary) for other prevailing charges.

Specifies that the procedures subject to the reductions are: cataract exraction with intraocular lens implant, intraocular lens insertion, coronary artery bypass surgery, total hip replacement, suprapubic prostatectomy, transurethral resection of the prostate, diagnostic dilation and curettage, pacemaker surgery, and carpal tunnel release.

(b) Actual Charge Limit.—Similar to Section 4001 except the first special limit applies for the 9-month period beginning April 1, 1988, and equals 125% of the reduced prevailing charge plus one-half of the difference between the 125% level and the 1987 MAAC.

Effective date.—Applies to procedures performed on or after April 1, 1988.

Conference agreement

(a) Payment Reduction.—The conference agreement includes the Senate amendment with a modification. The Secretary is required to reduce prevailing charges for the following selected overpriced procedures. The procedures (with corresponding HCPCS codes) are: coronary artery bypass surgery (33510–33528); total hip replacement (27130–27132); cataract surgery (66830–66985); transurethral prostatectomy (52601); suprapubic prostatectomy (55821); diagnostic and/or therapeutic dilation and curettage (58120); carpal tunnel neurolysis and/or transposition (64721); pacemaker surgery (33206–33208); bronchoscopy (31622–31626); upper gastrointestinal endoscopy (43235–43239); knee arthroscopy (29880–29881); knee arthroplasty (27446–27447). The conferees expect the Secretary to make appropriate changes to the list of procedure codes if the coding system changes from year to year.

The prevailing charges for the specified procedures are reduced by 2 percent for the 9 month period beginning April 1, 1988. The prevailing charges are further reduced by a straight-line sliding scale. The additional reduction is equal to $\frac{3}{13}$ of a percentage point for each percentage point by which the reduced prevailing charge exceeds 85 percent of the weighted national average of reduced prevailing charges. In no case can the reduction under the sliding scale reduce the prevailing charge below 85 percent of the national average of the prevailing charges (as reduced by the 2 percent).

The conferees expect that the provision will be implemented on April 1, 1988 and understand that HCFA will have minimal lead time. In view of time constraints and the highly technical nature of the calculations involved, the conferees intend that the Secretary should have sole discretion with regard to choice of data and methods used to calculate national average prevailing charges for purposes of setting the payment floor. Therefore, the conference agreement includes the Ways and Means provision which precludes judicial or administrative review of the Secretary's determination of prevailing charge floors.

The conference agreement provides that the Secretary shall develop a geographic index that reflects geographic differences in the relative costs of physician practice and costs of living compared to the national average.

(b) Actual Charge Limit.—The conference agreement includes the Senate amendment. The agreement consolidates current law provisions relating to calculation of MAAC.

3. Limits on Payments for Ophthalmic Ultrasound (Section 9263(a)(i) of House bill.

Present law

There are no special limits on payment for ophthalmic ultrasound procedures.

House bill

Limits the prevailing charge for A-mode ophthalmic ultrasound procedures to 5% of the prevailing charge level established for extracapsular cataract removal with lens implementation. The special limit on actual charges specified under Item 2, above applies to these services.

Effective date.—Applies to items and services furnished on or after January 1, 1988.

Senate amendment

No provision.

Conference agreeement

The conference agreement includes the House provision. The agreement limts Medicare reimbursement for ophthalmic ultrasound (A-scan) procedures (HCPCS codes 76511, 76516 and 76519 and any other similar codes) to 5 percent of the prevailing charge for cataract surgery with intraocular lens implantation (HCPCS code 66984).

4. Customary Charges for New Physicians (Section 4021(c) of Senate Amendment)

Current law

Under current carrier manual instructions in place since the early years of Medicare, customary charges of new physicians have been set at the 50th percentile of the weighted customary charge distribution for all physicians in the locality. This policy was initiated because it was necessary to establish the customary charge for a new physician until the physician has sufficient actual charges on which to base the customary charge. Actual payment to a new

physician is based on the lower of the physician's actual charge for the service, the physician's customary charge for the service (established at the 50th percentile) or the locality prevailing charge.

The carrier manual specifies that the 50th percentile will be used as the new physician's customary charge until the next fee screen update for which the carriers has at least three months actual charge experience for the physician in the same base period used to calculate the customary charges for established physicians. That is, with the update on January 1st of a year, a new physician must have actual charges for at least three months during the 12-month period ending June 30th of the previous year in order to base the new physician's customary charges on the physician's actual charges rather than the 50th percentile.

The new physician policy was established prior to the Medicare Economic Index, i.e., when the prevailing charge was set at the 75th percentile of customary charges in the locality unconstrained by the MEI. As a result of the application of the MEI, many situations arise whereby the 50th percentile is greater than the prevailing charge (as constrained by the MEI).

House bill

No provision.

Senate amendment

Requires the Secretary to set customary charges of new physicians, who do not practice in health manpower shortage areas as defined under the Public Health Service Act, at no more than 80 percent of the prevailing charge for the service.

Effective date.—Applies to physicians who first furnish services to Medicare beneficiaries after January 1, 1988.

Conference agreement

The conference agreement includes the Senate amendment with amendments. The Conference agreement restores the effect of the new physician policy for most new physicians by establishing the customary charges of most new physicians at no more than 80 percent of the prevailing charge as adjusted by the MEI for participating and non-participating physicians. The Senate bill retained the current customary charge method for a new physician in a rural underserved area. The Conference agreement preserves the Senate exemption and expands it to include primary care services for new physicians in all areas. This policy was adopted because of the concern that these services are undervalued in Medicare. The Conference agreement does not modify the current policy whereby physicians who move to new areas can take their customary charge profiles with them to the new area.

5. Payments to Anesthesiologists, Radiologists and Pathologists (Sections 4002, 4006, 4007, and 4008 of House Bill).

Present law

(a) Payments to Anesthesiologists.—Anesthesiologists services are reimbursed on a reasonable charge basis. Anesthesiologists may also bill for the supervision of one or more concurrent procedures performed by qualified anesthetists or certified registered nurse an-

esthetists (CRNAs). The reasonable charge for anesthesiology services is the sum of base, time, and modifier units times a conversion factor. The number of base units is determined by the procedure. The time units represent either (1) 15 minutes intervals if the physician performs the services or if the anesthetist or CRNA is employed by the physician, or (2) 30 minutes if the anesthetist or CRNA is employed by the hospital. If more than four concurrent procedures are supervised, the physician may bill only for pre-anesthesia services personally furnished to the patient. The reasonable charge in this case may not exceed the base units assigned the procedure plus one time unit.

OBRA reduced the base units allowed for anesthesia services provided in connection with cataract surgery and iridectomies from 8 to 4. If the physician supervises more than four concurrent services, no more than 3 base units are allowed.

(b) Payments to Radiologists.—(1) Radiology services, whether performed by any physician or by a physician either certified or eligible to be certified by the American Board of Radiology, are reimbursed on the basis of reasonable charges, determined by the lesser of the billed amount for the service, the customary charge by the physician for the service, and the prevailing charge for the service by all physicians in the pricing locality. After adjustment for the annual deductible amount, Medicare pays 80 percent of the reasonable charge.

(2) Participating physicians are physicians who have agreed to accept assignment on all claims for the forthcoming year; that is, to accept Medicare's reasonable charge as payment in full and not to bill the patient for any amount in excess of the reasonable charge. Non-participating physicians may bill the patient for amounts in excess of Medicare's reasonable charge on unassigned claims. The prevailing charges of non-participating physicians are 96 percent of the prevailing charges of participating physicians.

(3) If the Secretary reduces a prevailing charge using the inherent reasonableness authority, or for cataract surgery as required by OBRA, the actual charges of non-participating physicians are limited. In these cases, a non-participating physician's actual charge is (1) limited in the first year following a reduction to no more than 125 percent of the reduced prevailing charge plus half the difference between the reduced prevailing and the physician's actual charge for the service during the preceding year, and (2) limited to no more than 125 percent of the reduced prevailing charges in subsequent years.

(4) A physician's decision to become a participating physician applies to all services provided during the period of participation.

(5) Carriers make payments for services equal to 80 percent of the reasonable charge, adjusted for any applicable deductible amounts. The physician or supplier is responsible for collecting any deductible and coinsurance amounts from the beneficiary.

(6) The Secretary is required to develop a relative value scale for physician services and report to Congress no later than July 1, 1989. The report must include recommendations on the application of the scale to payments for physician services furnished after December 31, 1989.

(c) Pathology Services.—Pathology services under Part B are paid on the basis of reasonable charges, determined as the lesser of the billed amount for the service, the cusotmary charge by the physician for the service, and the prevailing charge for the service by all physicians in the pricing locality.

The Secretary is required to develop a relative value scale for all physician services and report to Congress no later than July 1, 1989. The report must include recommendations on the application of the scale to payments for physician services furnished after December 31, 1989.

(d) Prohibition of Prospective Payment System for "RAP" Services.—OBRA required the Secretary to study and report to Congress concerning the design and implementation of a prospective payment system for radiology, anesthesiology, and pathology services provided under Part B to hospital inpatients.

(a) Payments to Anesthesiologists.—Provides that, in determining the reasonable charge for the concurrent direction of 2 or more nurse anesthetists for services on or after January 1, 1988, the number of base units recognized (other than for cataract surgery or iridectomies) are reduced by 10 percent for 2 concurrent procedures, 25 percent for 3 concurrent procedures and 40 percent for 4 concurrent procedures. For 2 or more concurrent cataract and iridectomy procedures, the base units recognized are reduced by 10 percent. The Secretary shall require that claims for the supervision of CRNAs indicate the number and types of concurrent procedures, and the names of the CRNAs supervised.

Provides that the Secretary, in consultation with groups representing physicians who furnish anesthesia services, establish by regulation a relative value guide for use in all carrier localities in making payment for physician anesthesia services on or after January 1, 1989. The guide is to be designed to result in expenditures that would not exceed the amount of expenditures that would otherwise occur.

(b) Payments to Radiologists.—

(1) Requires that radiology services, performed by or under the direction of physicians that are either certified or eligible to be certified by the American Board of Radiololgy, are to be reimbursed at 80 percent of the lesser actual charge or a radiology fee schedule. The Secretary is required to develop a relative value scale (RVS) for radiology services. Using this RVS and appropriate conversion factors, the Secretary shall develop fee schedules (on either a regional, State-wide or carrier service area basis) for payment for radiology services under Part B. The Secretary shall also develop an appropriate index for updating the fee schedules annually for services provided in years after 1989.

Requires the Secretary in developing the RVS, fee schedules and updating index, to consult with the Physician Payment Review Commission, the American College of Radiology and other organizations representing physicians and suppliers who provide radiology services. The Secretary shall also share with these entities the data and data analyses used to develop the RVS, fee schedules and updating index, including data on current variations in Medicare payments by geographic area, and by services and physician specialty.

Requires the Secretary in developing the RVS, fee schedules and updating index, to consider variations in the cost of furnishing such services between geographic areas or, sites of service. The Secretary may take into consideration other factors respecting the manner in which physicians in different specialties furnish such services to assure equitable payment amounts and to promote effective and efficient provision of radiology services by physicians in different specialties.

Provides that the fee schedules are to be designed to produce aggregate savings (net of deductible and coinsurance amounts) of not more than $20 million for radiologic services provided in 1989, and of not less than $30 million for each year for services provided in 1990 and 1991.

(2) Requires that the fee schedule be established such that the payment rate recognized of non-participating physicians is equal to 96 percent of the payment rate for participating physicians.

(3) Requires that for radiology services that are furnished after January 1, 1989, are reimbursed on the basis of the fee schedule, and are billed by a non-participating physician, the actual charge may not exceed 125 percent of the fee schedule amount in 1989, 120 percent in 1990, and 115 percent after 1990. If a physician knowingly and willfully imposes a charge in excess of these amounts, the Secretary may bar the physician from the program for a period not to exceed five years, may impose civil money penalties, or both.

(4) Requires the Secretary to permit certain physicians and suppliers to enter into a participation agreement only with respect to radiologic services. These physicians and suppliers are those who furnish radiologic services that are performed by or under the direction of a physician who is either certified or eligible to be certified by the American Board of Radiologists and who are paid under the fee schedule.

(5) Requires that in the case of participating physicians and suppliers furnishing radiologic services, the carrier shall advance to the physician or supplier from the Supplementary Medical Insurance Trust Fund an amount equal to any coinsurance or deductible amounts. The carrier shall make arrangements to collect the amounts so advanced and return them to the Trust Fund. The Secretary shall establish appropriate guidelines for the advancing and collecting of these amounts.

(6) Requires the Secretary to establish the RVS and fee schedules and to report to Congress on the development of the fee schedules by not later than August 1, 1988.

(c) Pathology Services.—Requires the Secretary to develop a relative value scale (RVS) for pathology services. Using the RVS and appropriate conversion factors, the Secretary shall develop fee schedules (on a regional, State-wide or carrier service area basis) for payment of pathology services. The Secretary shall also develop an index for updating the fee schedules annually for services provided in years after 1990.

Requires the Secretary in developing the RVS, fee schedules and updating index to consult with the Physician Payment Review Commission, the American College of Pathologists and other organizations representing physicians who provide such services. The Secretary will share with these entities the data and data analyses

used to develop the RVS, fee schedules and updating index, including data on current variations in Medicare payments by geographic area, and by service and physician specialty. In developing the fee schedules, the Secretary shall consider variations in the cost of furnishing pathology services among geographic areas.

Requires the Secretary to report, not later than April 1, 1989, to the House Committees on Energy and Commerce and Ways and Means and Senate Finance Committee on the RVS, fee schedules and updating index. This report shall include recommendations on how to protect beneficiaries against excessive charges for pathology services in excess of the payment amounts established by the fee schedules.

(d) Prohibition of Prospective Payment System for "RAP" Services.—Provides that nothing in OBRA or any other provision of law shall be construed as authorizing or requiring the Secretary to implement a prospective payment system for inpatient radiology, anesthesiology, and pathology services. The Secretary is prohibited from conducting any new study or demonstration project designed specifically to reform the payment methodology for inpatient radiology, anesthesiology and pathology services unless specifically directed to do so under law.

Effective dates.—(a), (c), and (d) apply on enactment. (b) applies to services performed on or after January 1, 1989 and until such time as the Secretary implements physician fee schedules based on a relative value scale for all physician services.

Senate amendment

(a) Payments to Anesthesiologists.—No provision.
(b) Payments to Radiologists.—No provision.
(c) Pathology Services.—No provision.
(d) Prohibition of Prospective Payment System for "RAP" Services.—No provision.

Conference agreement

(a) Payments to Anesthesiologists.—The conference agreement includes the House provision with amendments.

The General Accounting Office is required to conduct two studies of payments to anesthesiologists for the supervision of CRNAs. The first GAO study shall examine whether the payments for physician supervision of CRNAs are excessive relative to payments for their physician services, and would study the appropriateness of anesthesia times reported for Medicare reimbursement purposes. To the extent feasible, the GAO shall examine differences in anesthesia input, skill, risk, etc. during different portions of the total time. The GAO shall also examine the extent to which physicians bill and carriers recognize modifier units for reimbursement purposes and the appropriateness of such billings. In conducting this study, the GAO shall focus on procedures accounting for the highest amount of Medicare anesthesia dollars. The GAO shall make recommendations regarding the appropriateness of the anesthesia times recognized by Medicare for reimbursement purposes and shall recommend ways to more narrowly define anesthesia times. The second GAO study concerns the impact of the payment reductions required under this provision with regard to the utilization of

CRNAs. In addition, the provision would only apply to services provided on or after April 1, 1988 and before January 1, 1991.

(b) Payments to Radiologists.—The conference agreement includes the House provision with amendments. The agreement strikes the provision permitting physicians to enter into participation agreements limited to radiologic services. Further, the agreement strikes the provision that would permit carriers to advance deductible and coinsurance amounts to participating physicians and suppliers and then to arrange to collect the amounts so advanced. The fee schedule would apply to radiology services provided by physicians that are board certified or board eligible, and physicians whose Medicare charges are at least 50 percent radiology services. The Secretary would develop a preliminary fee schedule which would be budget neutral in 1989 with respect to current law. For payment purposes, the amount if allowed is 97 percent of the fee schedule. The fee schedule would be updated by the MEI in subsequent years.

(c) Pathology Services.—The conference agreement includes the House provision.

(d) Prohibition of Prospective Payment System for "RAP" Services.—The conference agreement does not include the House provision. The conferees note that current law does not permit the Secretary to establish by regulation a DRG-based reimbursement system for "RAP" services. The conferees also believe that the Secretary should delay any demonstration of a RAP/DRG reimbursement system under Medicare until further studies have been completed.

6. Prohibition of Billing for Certain Purchased Services (Section 9264 of House Bill).

Present Law

(a) Payments for Diagnostic X-ray and Other Diagnostic Tests.—Diagnostic x-ray and other diagnostic tests (excluding diagnostic laboratory services) are reimbursed on a reasonable charge basis and may be billed by the physician ordering the test or by the entity performing the test, but not both. Diagnostic laboratory tests, paid on the basis of a fee schedule, must be billed by the physician or laboratory that actually performs the service, except that if a physician performed or supervised the test, payment may be made to a physician who shares a practice with the performing physician. If the physician does not perform the service, he may only bill for a specimen collection and handling fee.

(b) Adjustment in Medicare Prevailing Charges.—The Secretary may reduce the prevailing charge for a service if it is found that, according to certain guidelines and criteria, the charge for the service is inherently unreasonable. If the prevailing charge for a service is reduced under this authority, the actual charges of physicians are limited according to a specified procedure.

House bill

(a) Payments for Diagnostic X-ray and Other Diagnostic Tests.—Provides that payments under Part B for diagnostic x-ray and other diagnostic tests may only be made to the entity performing or supervising the provision of such tests. If a physician performs

or supervises such tests, payment may be made to another physician with whom the performing physician shares a practice.

Provides that a physician or supplier may not bill a beneficiary for a diagnostic test when payment may not be made because the physician did not perform the test. The Secretary may impose sanctions on physicians or suppliers who knowingly, willfully and repeatedly violate this rule. These sanctions may include suspension from the program for up to five years, civil money penalties, or both.

(b) Adjustment in Medicare Prevailing Charges.—Requires the Secretary to review payment levels for diagnostic x-ray and other diagnostic tests (excluding diagnostic laboratory services) which are commonly performed by independent vendors, sold as services to physicians and billed by such physicians to determine the reasonableness of payment amounts for such tests and the associated professional service components of such tests. If the Secretary finds, after appropriate notice and opportunity for public comment, that the prevailing charge levels are excessive, the Secretary shall establish new prevailing charges at levels that are consistent with maintaining wide and consistent access to the service, and that reflect the purchase price of the test without markup. The Secretary may, after appropriate notice and opportunity for public comment, establish guidelines for determining such new prevailing charges and may delegate the establishment of new prevailing charges to carriers.

Provides that if the prevailing charges are reduced, the actual charges for the services will be limited in accordance with the same rules that would apply in the case of a reduction under the inherent reasonableness authority, as modified by Item 2, Section 9362 above.

Effective dates.—(a) applies to diagnostic tests performed on or after January 1, 1988 except that the Secretary may delay the application of the provision until not later than January 1, 1989 in cases in which there are inadequate data to establish appropriate payment levels, (b) requires the Secretary to complete the review and make adjustments to prevailing charges for items and services furnished no later than January 1, 1989.

Senate amendment

No provision.

Conference agreement.

(a) Payments for Diagnostic X-ray and Other Diagnostic Tests.—The conference agreement contains the House provision with amendments. Under the conference agreement physicians would be allowed to bill for services purchased from outside vendors as under current law.

However, the conference agreement would eliminate the physician mark-up for services obtained from outside suppliers. The Medicare payment is limited to the actual acquisition cost for the purchased service (net of any discount). The physician is required to indicate the actual acquisition price on a request for payment.

The mark-up is eliminated as follows: If a physician bills a global fee for a service (i.e., a fee for technical and professional compo-

nents combined), then the carrier limits the global fee to the sum of (i) the reasonable charge for associate professional services plus (ii) the lower of the reasonable charge for the technical component of the test or the actual acquisition cost (net of any discount). If a physician bills separately for a technical and professional component, then separate limits apply. Carriers would gap-fill any professional component fees for which they did not have established allowances.

If a physician does not indicate the acquisition price from an outside vendor on the bill, then no payment may be made to the physician on an assigned basis and the physician is precluded from billing the beneficiary for such services on an unassigned basis subject to 1842(j) sanctions.

The conference agreement provides that this provision shall apply to services furnished on or after January 1, 1989.

(b) Adjustment in Medicare Prevailing Charges.—The conference agreement retains the House provision to require the Secretary to review Medicare allowances for purchased services and to reduce payments if they are excessive. In order not to encourage physicians to attempt to circumvent the mark-up limitation by purchasing equipment, performing in-office testing, and charging excessive prices, the Secretary is required to review allowances for similar types of diagnostic services which could be performed in physicians offices and reduce excessive payments. Where reductions are made, a limiting charge applies on unassigned billings of non-participating physicians based on 125 percent of the allowed charge.

The conference agreement provides that this provision shall apply to services rendered on or after January 1, 1989.

The conferees are concerned that there has been misunderstanding about this provision and some manufacturers of ambulatory cardiac monitors have inappropriately attempted to induce physicians to purchase machines to perform in-office testing. The conferees do not intend this provision to favor one type of ambulatory cardiac monitoring over another. Therefore, the conference agreement contains two provisions to address these concerns. The Secretary would be required to review allowances for purchased services and to reduce them if excessive. The review requirement would specifically also cover physician in-office testing. The conferees expect the Secretary to focus such review on high volume Medicare procedures and particularly expect the Secretary to review allowances for all types of ambulatory cardiac monitoring. Second, the conferees choose to request the Office of Technology Assessment to conduct a study concerning the accuracy and effectiveness of currently available methods of long-term ambulatory electrocardiography monitoring.

7. Completion of Forms for Unassigned Claims (Section 9265 of House Bill)

Present law

Physicians and suppliers may bill for their services on either an assigned or unassigned basis. On assigned claims, the physician or supplier submits the claim directly to the Part B carrier. On unassigned claims, the physician or supplier bills the patient who then

submits a claim to the carrier. The physician may submit bills for unassigned claims to the carrier on the beneficiary's behalf.

House bill

Requires that physicians who provide services to Medicare beneficiaries to submit a claim to the Part B carrier for all services, whether or not assignment is accepted. The physician must submit a claim to the carrier no later than when the bill for the service is submitted to the patient. The physician may not impose any charge for completing and submitting the claim forms. If a physician knowingly, willfully and repeatedly violates this requirement, the Secretary may suspend the physician from the program for not more than 5 years, impose civil money penalties, or both.

Effective date.—Applies to services furnished on or after January 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

8. Submission of Claims to Supplemental Insurance Carriers (Section 9266 to House Bill)

Present law

(a) Submission of Claims by Physicians and Suppliers.—Physicians and suppliers may bill for their services on either an assigned or unassigned basis. On assigned claims, the physician or supplier submits the claim directly to the Part B carrier. On receipt of payment for Medicare, the physician or supplier bills the patient, or the patient's supplemental health insurance policy if any, for the deductible and coinsurance amounts. On unassigned claims, the physician or supplier bills the patient who then submits claims for benefits to the carrier and to any supplemental health insurance plan.

(b) Medigap Certification Standards.—Section 1882 specifies standards and criteria for the voluntary certification of Medicare supplemental health insurance policies known as Medigap policies. Under this section, States may impose, either by regulation or legislation, standards on health insurance policies sold as Medicare supplemental policies.

House bill

(a) Submission of Claims by Physicians and Suppliers.—Requires the Secretary to establish procedures whereby a beneficiary receiving a service from a participating physician or supplier may assign his right to benefits under a Medicare supplemental policy to the physician or supplier. In such a case, the carrier processing the claim under Part B is required to transmit to the private entity issuing the supplemental policy such information as the Secretary determines is necessary for the private entity to determine the amounts payable under the policy. The Secretary may arrange for the electronic transmittal of such information for a reasonable fee.

(b) Medigap Certification Standards.—Amends the voluntary Medigap certification standards to require that entities administering such plans accept a notice from Medicare carriers as a claim form. When such notices are received, the plan must notify the physician or supplier, and the beneficiary of the payment determination and make appropriate payments directly to participating physicians or suppliers. The plans must provide each enrollee with a card listing the name, address and policy number. The plans annually must provide the Secretary with a mailing address to be used by carriers.

Effective dates.—(a) applies to contracts with carriers for claims for items and services furnished on or after January 1, 1989, (b) applies to Medicare supplemental policies as of January 1, 1989. If the Secretary identifies a State in which legislation is required to amend the Medigap certification standards and if the legislature is not scheduled to meet in 1988, the effective date is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1989.

Senate amendment

No provision.

Conference agreement

(a) Submission of Claims by Physicians and Suppliers.—The conference agreement includes the House provision with an amendment. The Secretary is required to charge supplemental insurance carriers a user fee to cover the costs of the transmittal of claims information to supplemental insurance carriers in either electronic or other form.

(b) Medigap Certification Standards.—The conference agreement includes the House provision.

9. Payments for Durable Medical Equipment. Prosthetic Devices, Orthotics, and Prosthetics (Sections 9263(a)(ii) and 4005 of House Bill: Section 4030 of Senate Amendment).

Present law

(a) Limits on Payment for Lens Implants for Cataract Surgery.—Intraoccular lenses (IOLs) implanted in a physician's office or ambulatory surgical center are reimbursed on a reasonable charge basis. IOLs implanted in hospital outpatient departments must be billed by the hospital and are reimbursed on a reasonable cost basis. Payments for IOLs furnished to hospital inpatients are included in the DRG payment.

(b) General Rules.—Durable medical equipment (DME), prosthetic devices, orthotics and prosthetics are reimbursed under Part B using a methodology similar to that used to pay for physician services—that is, the lesser of the actual charge, the supplier's customary charge, and a prevailing charge. Claims for these services and equipment may be billed on either an assigned or unassigned basis. Suppliers may elect to become participating suppliers and to accept assignment on all claims during participation periods.

Subject to guidelines issued by the Secretary, the Part B carriers determine for certain items whether to make payments on a

rental, lease-purchase or lump-sum purchase basis, depending on the item's cost and expected duration of use. The Secretary is to encourage suppliers to provide equipment on a lease-purchase basis whenever possible.

If the Secretary determines that certain devices or equipment do not vary in quality from one supplier to another, he may establish a "lowest charge level" at the price at which such services and supplies are widely available in a locality. The lowest charge level acts as an additional payment screen, similar to the customary and prevailing charge screens. The Secretary also has issued regulations establishing an "inflation indexed charge" screen. This screen is computed as the lowest of the existing fee screens (customary, prevailing and lowest charge level if applicable) updated by changes in the Consumer Price Index all urban consumers.

In some instances, such as when equipment is provided by a home health agency, the equipment may be reimbursed on the basis of reasonable costs.

Part B payments are made at 80 percent of the reasonable cost or charge levels determined under these rules, adjusted for the annual deductible. The Secretary may waive the 20 percent coinsurance amount for the purchase of used equipment if the purchase price is at least 25 percent less than the price of new equipment.

(c) Payment for Inexpensive DME.—Reimbursement for purchased inexpensive equipment (items costing less than $120), is made in a single payment. If a beneficiary has rented the equipment, rental payments can be on the basis of reasonable rental charges, up to the purchase price. Rental payments may be made beyond the purchase price if the equipment is not available for purchase, if neither the beneficiary nor supplier was aware the item was subject to these guidelines, or for rented respiratory equipment.

(d) Payment for Items Requiring Frequent and Substantial Servicing.—Repairs to a purchased item that are necessary to make the equipment serviceable are covered on a reasonable charge basis. Routine periodic servicing that is generally expected to be performed by the owner is not covered unless it must be performed by authorized technicians. The cost of repairs to rented items are covered under the rental charge.

(e) Payment for Certain Customized Items.—In general, these items are sufficiently unique that carriers do not develop customary and prevailing charge screens for them. Carriers generally make reasonable charge determinations on an item-by-item basis.

(f) Payment for Oxygen and Oxygen Equipment.—When prescribed by a physician for treatment of certain conditions, oxygen therapy services in the home are reimbursed on a reasonable charge basis. Payments for equipment are determined separately from payments for consumable oxygen. Payments for consumable oxygen are based on the amount of oxygen actually supplied. The use of oxygen tanks is reimbursed on the basis of monthly rental charges. Portable oxygen systems, either by themselves or as an adjunct to stationary oxygen systems, are covered if a physician provides a description of the routine activities of exercise that the patient must perform and if such activities are expected to result in

clinical improvement in the patient's condition. Portable oxygen systems are reimbursed on a reasonable charge basis.

(g) Payment for Other Covered Items (other than DME).—This category includes prosthetics and orthotics. Payment for these items is currently made on a reasonable charge basis under Part B.

(h) Payment for Other Items of DME.—Payment for these items is currently made on a reasonable charge basis under Part B. The Secretary may waive the 20 percent coinsurance amount for used equipment costing less than 75 percent of the price of new equipment.

(i) DME Qualifying for Long-term Rental.—No provision.

(j) Lease-purchase Option.—No provision.

(k) Billing Practices.—No provision.

(l) Regional Carriers.—No provision.

(m) Study and Evaluation.—No provision.

(n) Three-month Freeze on Increases in Payments.—No provision.

House bill

(a) Limits on Payments for Lens Implants for Cataract Surgery.—

Section 9263(a)(ii).—Provides that payment for IOLs implanted in a physician's office or an ambulatory surgical center are limited to acquisition cost for the lens (taking into account any discount) plus a handling fee not to exceed 10% of such acquisition cost. The special limit on actual charges specified under Item 2, Section 9362, above, applies to these services.

Section 4005.—No provision.

(b) General Rules.—

Section 9263.—No provision.

Section 4005.—Establishes six categories of DME, prosthetic devices (excluding parenteral and enteral nutritional nutrients, supplies and equipment), orthotics and prosthetics: (1) inexpensive DME (items costing less than $150), (2) items requiring frequent and substantial servicing, (3) certain customized items, (4) oxygen and oxygen equipment, (5) other covered items (not DME), and (6) other DME.

Provides for the calculation of reimbursement amounts applicable to each category. Program payments for services covered under this section (including items furnished by a home health agency under Part A) are equal to 80 percent of the lesser of the supplier's actual charge or the "reimbursement amount," adjusted for deductible amounts as required.

Provides that payments to public home health agencies (or to home health agencies who demonstrate that a significant proportion of their clients are low income) who furnish the item free of charge or for a nominal charge are equal to 80 percent of the fee schedule amount without reference to the actual charge.

Specifies that the reimbursement rules in this provision are the sole basis for paying for these items under both Parts A and B except as these items are provided to hospital inpatients and to residents of skilled nursing facilities whose stays are covered under Part A.

Provides for exceptions to the reimbursement amounts determined under this section to take into account the unique circumstances of items furnished in Alaska, Hawaii, and Puerto Rico.

(c) Payment for Inexpensive DME.—

Section 9263.—No provision.

Section 4005.—Provides that payment for inexpensive DME items whose purchase price does not exceed $150 shall be made on either a rental or purchase basis. If on a rental basis, the total payments may not exceed the amount that would have been paid if the item had been purchased, the amount recoginzed for purposes of reimbursement is the lowest of the actual charge, the specified payment limit or the customary payment limit.

Specifies that the payment limit in 1989 is the 75th percentile of customary charges for the rental or purchase of the item during the twelve month period ending June 30, 1986, increased by the percentage increase in the CPI for the 24 month period ending September 1988. The customary payment limit, calculated for each supplier, is the customary charge for rental or purchase of the item in 1988 increased by the percentage increase in the CPI for the twelve month period ending September 1988. In 1990 and subsequent years, the payment limit and customary payment limit equal the respective amount during the preceding year, increased by the percentage increase in the CPI for the 12 month period ending with September of the preceding year.

(d) Payment for Items Requiring Frequent and Substantial Servicing.—

Section 9263.—No provision.

Section 4005.—Provides that payments for items (such as ventilators, aspirators, IPPB machines, and nebulizers for which there must be frequent and substantial servicing to avoid risk to the patient are made on a monthly basis for the rental of the item. The amount recognized for purposes of reimbursement is the lowest of the actual charge, a specified payment amount and a customary payment limit.

Specifies that the payment amount in 1989 is the 75th percentile of all customary charges for the rental of the item during the twelve month period ending June 30, 1986, increased by the percentage increase in the CPI for the 24 month period ending September 1988. The customary payment limit for each supplier is the customary charge for rental of the item during 1988 increased by the percentage increase in the CPI for the twelve month period ending September 1988. In 1990 and subsequent years, the payment amount and customary payment limits equal the respective amount during the preceding year, increased by the percentage increase in the CPI for the 12 month period ending with September of the preceding year.

(e) Payment for Certain Customized Items.—

Section 9263.—No provision.

Section 4005.—Provides that for items not specifically identified or described in the common coding system established by the Health Care Financing Administration, payments are to be made; (1) for the lump sum purchase of the item based upon the carrier's individual consideration of the item; and (2) for lump sum payments on an as-needed basis for the reasonable and necessary maintenance of the item during the period of medical need. The payment levels are to be based upon carriers' consideration of the individual items.

(f) Payment for Oxygen and Oxygen Equipment—

Section 9263.—No provision.

Section 4005.—Provides that payment for oxygen and oxygen equipment is to be made on the basis of a single monthly payment for all oxygen equipment and supplies. The amount recognized for reimbursement is the lesser of the actual charge or monthly payment amount.

Specifies that the monthly payment amount for oxygen equipment and supplies is a weighted average of local and regional payment amounts (defined below). In 1989, the monthly payment amount is 75 percent of the local payment amount plus 25 percent of the regional amount. In 1990, the monthly payment amount is 50 percent of the local payment amount plus 50 percent of the regional payment amount. After 1990, the monthly payment amount is equal to the regional amount. Separate monthly payment amounts are estimated for (1) oxygen equipment and supplies and (2) portable oxygen equipment. The amount estimated with respect to portable oxygen equipment is used only to determine a monthly add-on to the basic monthly payment (described below) for patients using such equipment.

Provides that the local monthly payment amounts for oxygen equipment and supplies and for portable oxygen equipment are estimated from a base value equal to the total reasonable charges during the 6 months ending December 31, 1986, divided by the total number of months beneficiaries used the equipment and supplies during the 6 month period for which payment was made. The local monthly payment rate in 1989 is equal to 96 percent of the base period value increased by the percentage increase in the CPI during the 24 month period ending September 1988. The local monthly payment rate in 1990 is the 1989 local monthly payment rate increased by the percentage increase in the CPI during the 12 month period ending September 1989.

Provides that the regional monthly payment rates for 1989 and 1990 are the weighted average of the local monthly payment rates for carriers in the region, weighted by relative volume of all claims among carriers. For each subsequent year, the regional monthly payment amounts are the amounts recognized during the preceding year increased by the percentage increase in the CPI for the 12 month period ending September of the preceding year.

Provides that the monthly payment amounts recognized for reimbursement are constrained within certain limits. In 1989, the payment amounts recognized may not exceed 130 percent or be below 80 percent of the national average regional monthly payment amounts. In any subsequent year, the payment amounts recognized may not exceed 125 percent or be below 85 percent of the national average regional payment amounts.

Specifies that if a physician prescribes an oxygen flow rate exceeding 4 liters per minute, the payment amount recognized is increased by 50 percent. If a flow rate of less than 1 liter per minute is prescribed, the payment amount is reduced by 50 percent. Otherwise, payment would not vary by the amount of oxygen used or supplied.

Specifies that if portable oxygen equipment is prescribed, the payment amount recognized is determined according to the local

and regional payment amount rules for portable oxygen equipment described above, and are added onto the payments for stationary oxygen equipment and supplies. However, if a physician prescribes a flow rate of more than 4 liters of oxygen per minute, the payment is increased by the greater of the flow rate adjustment or the monthly amount for portable oxygen equipment but not both.

(g) Payment for Other Covered Items (other than DME).—

Section 9263.—No provision.

Section 4005.—Provides that payment for these items (not defined as DME and not included in any item above) is made in a lump sum for purchase of the item. The amount recognized for purchase is the lesser of the actual charge or a recognized purchase price for each item.

Specifies that the recognized purchase price for each item is a weighted average of local and regional purchase prices (defined below). In 1989, the recognized purchased price is 75 percent of the local purchase price plus 25 percent of the regional purchase price. In 1990, the monthly payment amount is 50 percent local plus 50 percent regional prices. After 1990, the recognized purchase price is equal to the regional prices.

Specifies that the local purchase price for an item is estimated from a base value equal to the 75th percentile of all customary charges for the purchase of the item in the area during the 6 month period ending December 31, 1986. The local purchase price in 1989 is equal to the base period price increased by the percentage increase in the CPI for the 24 month period ending September 1988.

Provides that the regional purchase prices for 1989 and 1990 are the weighted average of the local purchase prices for carriers in the region, weighted by relative volume of all claims amount carriers. For each subsequent year, the regional purchase prices are the amounts recognized during the preceding year increased by the percentage increase in the CPI for the 12 month period ending September of the preceding year.

Provides that the purchase prices recognized for reimbursement are constrained with certain limits. In 1989, the purchase prices recognized may not exceed 130 percent, or be below 80 percent of the national average regional purchase prices. In any subsequent year, the purchase prices recognized may not exceed 125 percent or be below 85 percent of the national average regional purchase prices.

(h) Payment for Other Items of DME.—

Section 9263.—No provision.

Section 4005.—Provides that payment for these items (defined as DME and not included in any item above) is on the basis of monthly rental payments. The monthly rental amount is 10 percent of the recognized purchase price for the item, where the purchase price is determined according to the rules described in (f) above. The amount recognized for payment is the lesser of the actual charge and the rental amount.

Provides that rental payments are made on a monthly basis for up to 15 months. If the period of medical necessity extends for a period beyond 15 months, no further rental payments will be made. During the subsequent 6 months of medical need, no additional

payments are made. During the first month of each succeeding 6 month period of medical need, a service and maintenance payment is made for parts and labor not covered under the supplier's or manufacturer's warranty as determined appropriate by the Secretary. The amount recognized for each such 6 month period is the lower of a reasonable maintenance and service fee established by the carrier or 10 percent of the recognized purchase price.

Specifies that for 1989, the rental amount established may not be more than 115 percent nor less than 85 percent of the prevailing charge established for the rental of the item in January 1987 increased by the percentage increase in the CPI for the 12 month period ending September 1988. For 1990, the rental amount may not be more than the maximum nor less than the minimum amounts established for 1989 increased by the percentage increase in the CPI for the 12 month period ending September 1989.

(i) DME Qualifying for Long-term Rental.—

Section 9263.—No provision.

Section 4005.—No provision.

(j) Lease-purchase Option.—

Section 9263.—No provision.

Section 4005.—No provision.

(k) Billing Practices.—

Section 9263.—No provision.

Section 4005.—Provides that no supplier for a covered item which is provided on a rental basis under this provision may charge an individual for the rental or servicing of the item after rental payments may no longer be made under this title. If a supplier knowingly and willfully violates this rule, the Secretary may sanction the supplier by barring him from the program for a period of up to 5 years, by imposing civil money penalties, or both.

(l) Regional Carriers.—

Section 9263.—No provision.

Section 4005.—Provides that the Secretary may designate one carrier for each region to process claims for items covered under this provision.

(m) Study and Evaluation—

Section 9263.—No provision.

Section 4005.—Requires that the Secretary monitor the impact of this provision on the availability of covered items and evaluate the appropriateness of the volume adjustment for oxygen and oxygen equipment. The Secretary must report to Congress, by not later than January 1, 1991, on the impact and evaluation and such report must include recommendations for changes, if any, in the payment methodology.

Prohibits the Secretary from conducting any demonstration project of alternative payment methodologies for items covered under this provision before January 1, 1991.

Requires the Secretary to provide, on written request, the data and information used in determining the payment amounts for items covered under this provision.

(n) Three-month Freeze on Increases in Payment.—

Section 9263.—No provision.

Section 4005.—No provision.

Effective date.—

Section 9263(a)(ii).—Applies to items and services furnished on or after January 1, 1988. With respect to establishment of a reasonable charge limit for IOLs, the special limits shall not apply for the first 12-month period and the reference to the following 12-month period is deemed a reference to 1988.

Section 4005.—Applies to items and services furnished on or after January 1, 1989.

Senate amendment

(a) Limits on Payments for Lens Implants for Cataract Surgery.—No provision.

(b) General Rules.—Establishes three categories of DME: (1) inexpensive items (costing less than $120), (2) DME designated by the Secretary as qualifying for long-term rental payments, and (3) all other DME. There is no provision for prosthetic devices, orthotics or prosthetics.

In general, current policy is maintained for inexpensive DME, except that total lease-purchase or rental payments for an item may not exceed 80 percent of the reasonable charge if bought on a lump-sum purchase basis. Payment for items identified by the Secretary as eligible for long-term rental are made on a reasonable charge basis, except that participating suppliers must provide the item on a lease-purchase basis if requested by a beneficiary.

(c) Payment for Inexpensive DME.—Provides that payment for inexpensive DME items first furnished to a beneficiary in 1988 whose prevailing charge does not exceed $120 shall be made on either a rental, lease purchase or lump-sum basis. The reimbursement amount is determined according to current policy. If provided on a rental or lease purchase basis, total program payments may not exceed 80 percent of the reasonable charge that would apply if the item had been purchased on a lump-sum basis. The Secretary may waive the 20 percent coinsurance amount for the purchase of used equipment whose price is more than 25 percent less than the prevailing charge for the purchase of new equipment.

Provides that the Secretary may adjust the $120 limit that defines that category of inexpensive DME for items first furnished to a beneficiary after 1988.

(d) Payment for Items Requiring Frequent and Substantial Servicing.—No specific provision. DME items requiring frequent and substantial servicing are grouped into one of three categories, inexpensive, eligible for long-term rental, or other, and reimbursed according to (b), (g), or (h) respectively.

(e) Payment for Certain Customized Items.—No specific provision. Customized DME items are grouped into one of three categories, inexpensive, eligible for long-term rental, or other, and reimbursed according to (b), (g), or (h) respectively.

(f) Payment for Oxygen and Oxygen Equipment.—No specific provision. These items and services are grouped into one of three categories, inexpensive, eligible for long-term rental, or other, and reimbursed according to (b), (g), or (H) respectively.

(g) Payment for Other Covered Items (other than DME).—No provision.

(h) Payment for Other Items of DME.—Provides that payment for DME not defined as inexpensive or designated by the Secretary as

eligible for long-term rental is made on either a lump-sum or lease-purchase basis. Purchase on a lump-sum basis is permitted only if the expected duration of medical need for the equipment warrants a presumption that purchase would be less costly than purchase on a lease-purchase basis. If payment is made on a lease-purchase basis and on an assigned basis, the total payment (including any coinsurance) may not exceed an amount equal to the reasonable charge for purchase on a lump-sum basis plus a fair three-month rental charge. Title to the equipment passes to the beneficiary when the maximum payment amount is reached. If payment is not made on the basis of assignment, total program payments may not exceed 80 percent of the reasonable charge on a lump-sum purchase basis, except as provided for the purchase of used equipment.

(i) DME Qualifying for Long-term Rental.—Provides that the Secretary may designate items of DME as eligible for long-term rental.

(j) Lease-purchase Option—Provides that if a participating supplier offers DME equipment other than inexpensive equipment for either purchase or rental, the supplier must offer to provide the equipment on a lease-purchase basis at the option of the beneficiary.

(k) Billing Practices.—Provides that if durable medical equipment is rented on the basis of assignment, the beneficiary is entitled to use the equipment as long as the item is required without any additional charge beyond the 20 percent coinsurance.

(l) Regional Carriers.—No provision.

(m) Study and Evaluation.—No provision.

(n) Three-month Freeze on Increases in Payments.—Requires that the payment screens used to determine the payment level for DME and for determining payments for other nonphysician services paid on a reasonable charge basis under Part B are frozen through March 31, 1988 at the levels in effect on December 31, 1987. Through January 15, 1988, the benefit payments would also reflect the sequestration reductions as required under this Act. Adjustments in payments that would have become effective on January 1, 1988 shall become effective on April 1, 1988. The adjustment in the inflation index charge for DME that becomes effective on January 1, 1989 shall be 75 percent for the adjustment that would otherwise he made on that date. Participation agreements with suppliers for 1987 shall continue in effect through March 31, 1988, unless the participating supplier requests that the agreement be terminated. The effective period for participation agreements in 1988 will be the nine month period beginning on April 1, 1988.

Effective date—(n) Applies on enactment; all other provisions apply to equipment first furnished an individual on or after April 1, 1988.

Conference agreement

(a) Limits Payments for Lens Implants for Cataract Surgery.—The conference agreement includes the House bill with an amendment limiting the handling fee in physicians' offices to 5 percent of the acquisition cost. The agreement provides that, with respect to IOL's furnished in ambulatory surgical centers, payment is incorporated into the facility fee in an amount which is reasonable and related to

the acquisition cost. For this purpose, the Secretary may establish categories of IOL's based on differences in type and cost.

(b) General Rules.—The conference agreement follows the House bill as included in Section 4005 with amendments as described in the following sections. That is, a fee-schedule is established for each of 6 categories of services. The conference agreement provides that the fee-schedules will be used to determine payments for items and services provided on or after January 1, 1989.

(c) Payment for Inexpensive DME.—The conference agreement includes the House bill with amendments. The agreement provides that payment for inexpensive DME (items whose purchase price does not exceed $150 or that the Secretary determines are acquired by purchase at least 75 percent of the time) shall be made on either a rental or purchase basis. If on a rental basis, the total payments may not exceed the amount that would have been paid if the item had been purchased; the amount recognized for purposes of reimbursement is the lower of the actual charge and the specified payment amount.

The agreement specifies that the payment amount in 1989 is the average allowed charge for the 12 months ending June 30, 1987, for rental or purchase, increased by the percentage increase in consumer price index for the 6 months ending December 31, 1987. In subsequent years, the payment amount is increased by the increase in the consumer price index for the 12 month period ending in June.

(d) Payment for Items Requiring Frequent and Substantial Servicing.—The conference agreement includes the House bill with amendments. The agreement provides that payments for items (such as ventilators, aspirators, IPPB machines, and nebulizers) for which there must be frequent and substantial servicing to avoid risk to the patient are made on a monthly basis for the rental of the item. The amount recognized for purposes of reimbursement is the lower of the actual charge and the specified payment amount.

The agreement specifies that the payment amount in 1989 is the average allowed charge for rental of the item during the 12 month period ending June 30, 1987, increased by the percentage increase in the CPI for the 6 month period ending December 31, 1987. In subsequent years, the amount is increased by the percentage increase in the CPI for the 12 month period ending in June.

(e) Payment for Certain Customized Items.—The conference agreement includes the House bill with amendments. The agreement provides that payment for items that are uniquely constructed to meet the specific needs of an individual patient are to be made: (1) for the lump sum purchase of the item based upon the carrier's individual consideration of the item; and (2) for lump sum payments on an as-needed basis for the reasonable and necessary maintenance of the item not covered by the supplier's or manufacturer's warranty during the period of medical need. The payment levels are to be based upon carriers' consideration of the individual items.

(f) Payment for Oxygen and Oxygen Equipment.—The conference agreement includes the House bill with amendments. The agreement provides that payment for oxygen and oxygen equipment is to be made on the basis of a single monthly payment for all oxygen equipment and supplies. The amount recognized for reimbursement

is the lesser of the actual charge or a specified monthly payment amount.

The agreement provides that the monthly payment amount for oxygen equipment and supplies is a weighted average of local and regional payment amounts (defined below). In 1989 and 1990, the monthly payment amount is 100 percent of the local average monthly rate. In 1991, the monthly payment amount is 75 percent of the local payment amount plus 25 percent of the regional amount. In 1992, the monthly payment amount is 50 percent of the local payment amount plus 50 percent of the regional payment amount. After 1992, the monthly payment amount is equal to the regional amount. Separate monthly amounts are estimated for (1) oxygen equipment and supplies and (2) portable oxygen equipment. The amount estimated with respect to portable oxygen equipment is used only to determine a monthly add-on to the basic monthly payment (described below) for patients using such equipment.

The conference agreement provides that the local monthly payment amounts for oxygen equipment and supplies and for portable oxygen equipment are estimated from base value equal to the total reasonable charges during 12 months ending December 31, 1986, divided by the total number of months beneficiaries used the equipment and supplies during the 12 month period for which payment was made. The local monthly payment rate in 1989 is equal to 95 percent of the base period value increased by the percentage increase in the CPI during the 12 month period ending December 1987. The local monthly payment rate in 1990 and 1991 is the local monthly payment rate for the previous year increased by the percentage increase in the CPI during the 12 month period ending in June.

The agreement provides that the regional monthly payment rates for 1990, 1991, and 1992 are the weighted average of the local monthly payment rates for carriers. For each subsequent year, the regional monthly payment amounts are the amounts recognized during the preceding year increased by the percentage increase in the CPI for the 12-month period ending June of the preceding year.

In 1991, the payment amounts recognized may not exceed 130 percent or be below 80 percent of the national average monthly payment amounts. In any subsequent year, the payment amounts recognized may not exceed 125 percent or be below 85 percent of the national average regional payment amounts.

(g) Payment for Other Covered Items (other than DME).—The conference agreement includes the House bill with amendments. The agreement provides that payment for these items (not defined as DME and not included in any item above) is made in a lump sum for purchase of the item. The amount recognized for purchase is the lesser of the actual charge or a recognized purchase price for each item.

The agreement provides that the recognized purchase price for each item is a weighted average of local and regional purchase prices (defined below). In 1989 and 1990, the recognized purchase price is 100 percent of the local price. In 1991, the recognized purchase price is 75 percent of the local purchase plus 25 percent of the regional purchase price. In 1992, the monthly payment amount is 50 percent local plus 50 percent regional prices. After 1992, the

recognized purchase price is equal to the regional prices. The local purchase price for an item is estimated from a base value equal to the average allowable charge for the purchase of the item in the area during the 12-month period ending June 30, 1987. The local price in 1989 is the average price for the purchase of the item increase by the CPI for the 6 months ending December 1987. In 1990, 1991 and 1992, the local purchase price is equal to the price during the preceding year increased by the percentage increase in the CPI for the 12 month period ending June.

The regional purchase prices for 1991 and 1992 are the weighted average of the local purchase prices for carriers in the region, weighted by relative volume of all claims among carriers. For each subsequent year, the regional purchase prices are the amounts recognized during the preceding year increased by the percentage increase in the CPI for the 12-month period ending June of the preceding year. The purchase prices recognized may not exceed 130 percent, or be below 80 percent of the national average purchase prices. In any subsequent year, the purchase prices recognized may not exceed 125 percent or be below 85 percent of the national average purchase prices.

(h) Payment for Other Items of DMF.—The conference agreement includes the House bill with amendments. The agreement provides that payment for these items (defined as DME and not included in any item above) is on the basis of monthly rental payments. The monthly rental amount is 10 percent of the recognized purchase price for the item, where the purchase price is determined in a manner similar to the rules described in (g) above using actual submitted charges for the purchase price of these items. The amount recognized for payment is the lesser of the actual charge and the rental amount. The agreement specifies that for 1989, the rental amount established may not be more that 115 percent nor less than 85 percent of the prevailing charge established for the rental of the item in January 1987 increase by the percentage increase in the CPI for the 6 month period ending December 1987. For 1990, the rental amount may not be more than the maximum nor less than the minimum amounts established for 1989 increased by the percentage increase in the CPI for the 12-month period ending June 1989.

(i) DME Qualifying for Long-term Rental.—The conference agreement does not include the Senate amendment.

(j) Lease-purchase Option.—The conference agreement does not include the Senate amendment.

(k) Billing practices.—The conference agreement includes the House bill with amendments. The Secretary is authorized to require, for specified covered items, that payments may only be made if a physician has ordered the item or service prior to delivery. In order to permit a physician to establish a need for TENS, (purchase codes E0720 and EO729), the Secretary may provide for the rental of such item for not more than 2 months. If the item is then determined to be appropriate for the patient, payment would be made in accordance with the rules governing inexpensive equipment.

(l) Regional carriers.—The conference agreement includes the House bill.

(m) Study and Evaluation.—The conference agreement includes the House bill with amendments. The Secretary is prohibited from conducting any demonstrations of alternative methods of paying for DME items and services prior to January 1, 1991. The GAO is to conduct a study, due January 1, 1991, of DME payment levels and to make recommendations on the transition to regional or national rates.

(n) Three-months Freeze on Increases in Payments.—The conference agreement includes the Senate amendment with modifications. The payment screens used to determine the payment level for DME and for determining payments for other nonphysician services paid on a reasonable charge basis under Part B are frozen through December 1988 at the levels in effect on December 31, 1987. Through March 31, 1988, the benefit payments would also reflect the sequestration reduction as provided under Section 4061 of the Act. The conferees note that the 1-year freeze applies to all payment screents in effect in December 1987.

10. Clinical Diagnostic Laboratory Tests (Section 4033 of Senate amendment)

Present law

(a) Payments.—Payment for clinical laboratory services are made on the basis of two fee schedules. One fee schedule is established for laboratory tests performed either in a physician's office or by an independent laboratory (including a hospital laboratory furnishing serivces to persons who are not patients of the hospital). A second schedule is established for hospital laboratory services provided by a qualified hospital laboratory to a hospital's outpatients.

For the period beginning July 1, 1984, the rates under both schedules were established on a regional, statewide, or carrier service area basis. The first fee schedule was set at 60 percent of the prevailing charge levels established for the fee screen year beginning July 1, 1984. The second fee schedule was set at 62 percent of the prevailing charge levels established for the fee screen year beginning July 1, 1984. The fee schedules are adjusted annually to reflect urban consumers. Beginning July 1, 1986, the Secretary is required to establish payment ceilings for each test to be applied nationwide. Form July 1, 1986, through December 31, 1987, the ceiling is set at 115 percent of the median of all the fee schedules established for a particular test in a particular laboratory setting. Beginning January 1, 1988, until such time as a fee schedule for a test has been established on a nationwide basis, the ceiling is set at 110 percent of the median of all the fee schedules established for a particular test in a particular laboratory setting. Beginning January 1, 1990, the fee schedule for tests independent laboratory is to be established on a national basis.

(b) Intermediate Sanctions.—Medicare law requires that independ laboratories, situated in a State which a State or local law provides for licensing, to be licensed pursuant to such law or be approved by the agency of the State or locality responsible for such licensure as meeting the standards established for licensing. Further they much meet such other conditions as the Secretary finds necessary to assure the health and safety of individuals with respect to whom the tests are performed.

House bill

(a) Payments.—No provision.
(b) Intermedate Sanctions.—No provison.

Senate amendment

(a) Payments.—Provides for rebasing the fee schedules, effective January 1, 1988 (sic). The base percentage is reduced to 55% of the prevailing charge levels for independent laboratories and 57% for qualified hospital laboratories.

Provides that the payment ceiling for a test for the period after December 31, 1987 and before January 1, 1989 is equal to 100 % of the median of all fee schedules established for that test for that setting. After December 31, 1988, the level is equal to 97% of the median of all fee schedules established for that test for that setting.

(b) Intermediate Sanctions.—Authorizes intermediate sanctions (in lieu of immediately cancelling the certification of a provider or clinical laboratory) in the case of any provider or clincial laboratory certified for participation under Medicare which no longer substantially meets the conditions of participation specified with respect to the provision of clinical laboratory services under Part B.

Requires the Secretary to develop and implement (1) a range of intermediate sanctions to apply to such providers or certified clinical laboratories, and (2) appropriate appeals procedures relating to imposition of sanctions. The intermediate sanctions must include (1) directed plans of correction, (2) civil fines and penalties, (3) payment for the costs of onsite monitoring by an agency responsible for conducting certification surveys; and (4) suspension of part or all of the payments to which a provider or certified clinical laboratory would otherwise be entitled under Medicare for clincial diagnostic laboratory tests provided on or after the date the Secretary determines intermediate sanctions should be imposed.

Specifies that the new sanctions are in addition to sanctions otherwise available under State or Federal law.

Requires the Secretary to develop and implement specific procedures with respect to when and how each of the intermediate sanctions is to be applied, the amount of any fines and the severity of the penalties. The procedures are to be designed so as to minimize the time between identification of violations and imposition of these sanctions incrementally more severe fines for repeated of uncorrected deficiences.

Effective date.—(a) January 1, 1988 (b) January 1, 1990.

Conference agreement

(a) Payments.—The conference agreement includes the Senate amendments with modifications. The differential between the fee schedules for hospital outpatient laboratories and other laboratories is eliminated except for sole community hospitals.

The agreement provides for rebasing the fee schedules for automated tests (HCPCS codes 80002–80019 and for tests (with the exception of cytopathology) that were subject to the lowest charge provision prior to completion of the clinical lab fee schedule in 1984.

The rebasing is accomplished by reducing fee schedules for these tests by 8.3 percent for 1988.

The agreement provides that the payment ceiling for a test performed for the nine-month period beginning April 1, 1988, is equal to 100 percent of the median of all fee schedules established for that test for that setting. Beginning January 1, 1989, the level is equal to 100 percent of the median of all fee schedules established for that test for that setting. The agreement provides for no CPI update for 4/1/86 and there is catch-up.

The conference agreement provides for a GAO study of the level of fee schedules established under this provision to determine, based on the costs of revenues received for such services, the appropriateness of such schedules. GAO is required to report the results to Congress by January 1, 1990. Suppliers would be required to provide reasonable access to records containing cost and revenue data. Failure to provide access would result in sanctions.

The conference agreement provides that high-volume physician office laboratories performing over 5,000 tests a year (including medicare and non-medicare) will be treated as independent laboratories; that is, the same Medicare conditions for coverage that apply to independent laboratories will apply in these settings. The intent of this provision is to extend regulation of physician office laboratories beyond those doing referral work, to those performing a high volume of tests on their own patients. The conferees intend, through this requirement, to hold physician office laboratories doing a large volume of laboratory testing to the same standards that apply to independent laboratories. The requirement of state certification would be effective on January 1, 1990.

(b) Intermediate Sanctions.—The conference agreement includes the Senate amendment.

11. Elimination of Return on Equity for Outpatient Hospital Services (Section 9267 of House Bill; Section 4025 of Senate Amendment).

Present law

The Secretary is authorized to issue regulations providing for payment of a return on equity capital to proprietary providers for services reimbursed on a reasonable cost basis. If the Secretary elects to provide for a return on equity, the payment must be equal to the average rates of increase on obligations issued for purchase by the Part A Trust Fund. Providers reimbursed on a reasonable cost basis include hospitals and hospital outpatient departments.

House bill

Eliminates the Secretary's authority to pay return on equity with respect to the costs of hospital outpatient departments.

Effective date.—Applies to cost reporting periods beginning on or after October 1, 1987.

Senate amendment

Provides that regulations providing for payment of a return on equity capital may not include specific recognition of return on equity capital with respect to hospital outpatient departments.

Effective date.—January 1, 1988.

Conference agreement

The conference agreement includes the Senate amendment.

12. Payments to Hospital Outpatient Departments for Radiology (section 4022 of Senate Amendment.

Present law

Hospital outpatient departments are paid the lesser of their reasonable costs or charges for radiology services.

House bill

No provision.

Senate amendment

Provides for a limit to the aggregate payment for the non-capital costs of outpatient hospital radiology services (including diagnostic and therapeutic radiology, nuclear medicare and CAT scan procedures). The limit is based on a blended amount of the non-capital related costs and the prevailing charges that would apply if the services had been performed in a physician's office in the same locality.

The term "cost proportion" is defined as 65 percent for cost reporting periods beginning in FY 1989 and 50 percent for subsequent years. The term "charge proportion" is defined as 35 percent for cost reporting periods beginning in FY 1989 and 50 percent in subsequent years.

The "blend amount" for radiology services is defined as the sum of: (1) the hospital's reasonable costs of providing the radiologic services, excluding capital related costs, times the cost proportion; and (2) 62 percent of 80 percent of the prevailing charges for participating physicians for the same services, times the charge proportion.

The aggregate reimbursement limit is the amount for the capital costs related to the radiologic services plus the lesser of the hospital's reasonable costs (excluding amounts for capital) and the blend amount.

Effective date.—Applies to cost reporting periods beginning on or after October 1, 1988.

Conference agreement

The conference agreement includes the Senate amendment with amendments. Radiology services included under the limit also include magnetic resonance imaging services and diagnostic ultrasound and other imaging procedures. In addition, the limit includes both non-capital and capital costs. Effective October 1, 1989, payment for other diagnostic procedures provided in hospital outpatient departments are included under the same aggregate limit. The limit for these additional procedures would be based on 42 percent of the prevailing charge or on other appropriate percentage(s) if determined by the Secretary to be appropriate or by the carriers (acting pursuant to guidelines issued by the Secretary). Such alternative percentage(s) would be based on the technical component for the service as a percent of the total charge for the service. The conference agreement provides that this provision is effective for radi-

ology services rendered on or after October 1, 1988 and other diagnostic procedures for services rendered on or after October 1, 1989.

13. Payment for Ambulatory Surgery at Eye and Ear Specialty Hospitals (Section 4032 of Senate Amendment).

Present law

OBRA provided for a modification in payments to hospitals outpatient departments (OPDs) for ambulatory surgical procedures when such procedures have been approved for ambulatory surgical centers (ASCs). Payment for such OPD services is the lesser of the OPD's costs or charges (in the aggregate) net of cost sharing, or a blend of hospital costs and ASC rates. The blend is 75/25 for cost reporting periods beginning in FY88 and 50/50 thereafter. The law does not make any distinctions based on hospital specialties.

House bill

No provision.

Senate amendment

(a) Payment Rates.—Modifies the OBRA provision in the case of a hospital that: (1) specializes in eye or ear surgical procedures (as determined by the Secretary); (2) receives more than 30% of its total revenues from outpatient procedures; and (3) was an eye and ear specialty hospital or an eye specialty hospital on October 1, 1987. For a hospital meeting these requirements and making applications to the Secretary, the 75/25 blend of the hospital's reasonable cost and the ASC rate is retained for cost reporting periods beginning in fiscal years after 1988.

(b) Study on Payment Rates.—Requires the Secretary to conduct a study on modifying the payment amounts specified under the OBRA provision with respect to hospitals that specialize in specific surgical procedures. The Secretary is required to report the results to Congress within one year of enactment.

Effective date.—Effective as if included in OBRA.

Conference agreement

(a) Payment Rates.—The conference agreement includes the Senate amendment with amendments. The 75/25 blend of a hospital's reasonable costs and the ASC rate applies only to cost reporting periods beginning in fiscal years 1989 and 1990, reverting to a 50/50 blend for cost reporting periods beginning after October 1, 1990.

(b) Study on Payment Rates.—The conference agreement includes the Senate amendment with modifications. In conducting the study required by OBRA (86) to develop a prospective payment system for outpatient ambulatory surgery, the Secretary is required to consider whether a payment differential for specialty hospitals is appropriate. The Secretary shall solicit recommendations from the Prospective Payment Assessment Commission on the Prospective payment system for ambulatory surgery and on the model reimbursement system for non-surgical outpatient services. Such recommendations shall be included in the reports to Congress on these systems.

14. Medicare Payment for Therapeutic Shoes for Individuals With Severe Diabetic Foot Disease (Sections 9268 and 4025 of House Bill; Section 4029 of Senate Amendment)

Present law

Orthopedic shoes and other supportive devices for the feet are specifically excluded from coverage from Medicare.

House bill

(a) Coverage.—

Section 9268.—Provides that custom molded shoes, extra depth shoes with or without inserts and inserts for such shoes, prescribed by a podiatrist or other qualified physician and provided by a podiatrist or other qualified individual (as defined by the Secretary), are a covered service for diabetic individuals who are certified by a physician as being at risk for certain foot diseases. The shoes would not be covered if provided by the physician that certified the need for the shoes unless the Secretary finds that the physician is the only qualified individual in the area.

Section 4025.—Similar provision except that extra depth shoes without inserts and inserts by themselves are not specifically cited as a covered benefit.

(b) Limitation on Benefit.—

Section 9268.—Provides that the benefit is limited to no more than one pair of shoes or inserts per individual per calendar year and that payment for the shoes includes any expense for the fitting of such shoes. In the first year, payment is limited to $300 for custom molded shoes, $100 for extra-depth shoes and $50 for inserts. The Secretary may establish lower limits for shoes if shoes and inserts are readily available at lower prices. In subsequent years, the payment limits are to be increased the same percentage as the Secretary provides for durable medical equipment, rounded to the nearest dollar.

Section 4025.—Similar provision except that the annual limit to no more than one pair of shoes does not apply to inserts.

(c) Contingent Effective Date; Demonstration Project.—

Section 9268.—No provision.

Section 4025.—No provision.

Effective date.—

Section 9268.—Applies to shoes and inserts furnished on or after January 1, 1988.

Section 4025.—Applies to shoes furnished on or after January 1, 1988.

Senate amendment

(a) Coverage.—Identical provision to Section 4025.

(b) Limitation on Benefit.—Identical provision to Section 4025.

(c) Contingent Effective Date; Demonstration Project.—Provides that when and if coverage for therapeutic shoes becomes effective is to be based on the results of a demonstration project. The Secretary is required to conduct a demonstration project to test the cost-effectiveness of furnishing therapeutic shoes under Medicare to a sample of beneficiaries. The project shall begin on October 1, 1988 and continue for a period of 24 months. Not later than October 1,

1990, the Secretary shall report to Congress on the results of the project. If the Secretary finds the coverage to be cost-effective, the demonstration project would be discontinued, and the provisions providing coverage for therapeutic shoes would become effective on November 1, 1990. If the Secretary cannot make such a finding, the demonstration project would continue for an additional 24 months. The Secretary is required to submit a final report to Congress on the results of the study not later than April 1, 1993. The provisions providing coverage of therapeutic shoes would become effective on the first day of the first month after the final report is submitted unless the Secretary finds that such coverage is not cost-effective, in which case coverage would not be effective.

Effective date.—(c) is effective on enactment. Effective date of (a) and (b) is contingent on the outcome of demonstration project described in (c).

Conference agreement

(a) Coverage.—The conference agreement includes the Senate amendment.

(b) Limitation on Benefit.—The conference agreement includes the Senate amendment.

(c) Contingent Effective Date; Demonstration Project.—The conference agreement includes the Senate amendment.

15. Part B Premium (Section 4023 of Senate Amendment).

Present law

Under the original Medicare law, beneficiary premiums paid for 50% of the cost of Part B with the remaining 50% financed by Federal general revenues. However, between 1974 and 1983, the law limited the percentage increase in Part B premiums to the percentage increase in Social Security cash benefits payments.

TEFRA (as amended by the Social Security Amendments of 1983) specified that enrollee premiums in 1984 and 1985 would be allowed to increase to amounts necessary to produce equal to 25% of program costs for elderly enrollees. If there is cost-of-living (COLA) increase, the monthly premium would not be increased in that year. If the amount of the premium increase is greater than the Social Security COLA, the premium increase is to be reduced so as to avoid a reduction in the individual's social security check. Subsequent legislation extended these provisions through 1988. Beginning in 1989, the premium calculation reverts to the earlier method.

House bill

No provision.

Senate amendment

Extends for one year, through calendar year 1989, the current 25% payment provision, the provision specifying that no increase in the premium will occur if there is no social security COLA, and the provision holding beneficiaries harmless from a reduction in their social security checks as a result of the premium increase.

Effective date.—Enactment.

Conference agreement

The conference agreement includes the Senate amendment.

It is the expectation of the conferees that the monthly increase in the Part B premium on January 1, 1989 due to the extension of the 25% rule through fiscal year 1989 will be no more than the $2.00 a month projected by the Congressional Budget Office in the estimate submitted to the Congress on December 21, 1987.

The Committees on Ways and Means, Energy and Commerce and Finance will closely monitor payments to physicians and other Part B providers that affect the Part B premium.

Furthermore, it is the intention of the conferees that the Health Care Financing Administration submit to Congress the analysis used to set the Part B premium for January 1, 1989 in time for Congress to act prior to any increase in the premium that would take effect on January 1, 1989.

16. Increase in Part B Deductible (Section 4034 of Senate amendments).

Present law

Enrollees in the Part B program must pay the first $75 of covered expenses (known as the deductible) each year before any benefits are paid. The amount of the deductible is fixed by law. When the program was first enacted, it was set at $50. It was subsequently increased to $60 in 1972 and $75 in 1982.

House bill

No provision.

Senate amendment

Increase Part B deductible to $85.

Effective Date.—Applies with respect to calendar years after 1988.

Conference agreement

The conference agreement does not include the Part B deductible. In lieu of this provision, the conferees agreed to the re-imposition of beneficiary cost sharing for services provided by physicians in ambulatory surgical centers, effective April 1, 1988.

17. Providing Community Nursing and Ambulatory Care on a Prepaid Capitated Basis to Medicare Beneficiaries (Sections 9269 and 4071 of House bill; Section 4085 of the Senate Amendment).

Present law

No provision.

House bill

(a) Demonstration Projects.—

Section 9269.—Requires the Secretary to conduct demonstrations, in at least 4 sites, of a prepaid community nursing system, which would furnish home health care and other part B Medicare services as determined by the Secretary to enrollees. Services could not include outpatient hospital, physician, lab or x-ray. Requires that the community nursing organization follows the orders of attend-

ing physicians as they relate to community nursing services in accordance with standards established by the Secretary. The organization would be reimbursed on a prepaid capitated basis similar to that used for HMOs and CMPs.

Provides that the projects could involve financial risk-sharing or other assurances that the organization will minimize substitution of other Medicare services for the services for which the organization was responsible. The Secretary is authorized to terminate any project failing to meet any requirements, including requirements related to financial responsibility of institutional care.

Provides that expenditures for the demonstration projects are to be made, in appropriate parts, from the part A and part B trust funds. The Secretary is authorized to establish necessary payment conditions and terms, and to ensure that aggregate payments for the demonstrations may not exceed the aggregate payments which would have been made in the absence of the demonstrations.

Authorizes the Secretary to waive Medicare requirements to the extent and for the period necessary to conduct the demonstrations. The Secretary is required to report to the Congress within 4 days after enactment on the demonstrations and on the advantages and disadvantages of Medicare prepared community nursing.

Section 4071.—No provision.

(b) Contracts with Community Nursing and Ambulatory Care Organizations (CNACOs).—

Section 9269.—No provision.

Section 4071.—Provides that any Medicare beneficiary enrolled in both part A and part B, except a beneficiary who has end-stage renal disease or who is already enrolled in another prepaid program, may enroll in a CNACO in his or her area which has entered into a contract with the Secretary. Services provided by a CNACO include part time home nursing and home health aid services; physical, occupational and speech therapy; social services; durable medical equipment, prosthetics, and other medical supplies; ambulance services; and services of rural health clinics and clinical psychologists.

(1) Provides that to qualify as a CNACO, an entity must be primarily engaged in the direct provision of community nursing and ambulatory care, provide or arrange for such care through qualified personnel, supervised by a registered nurse and governed by policies developed by a registered professional nurse. The CNACO must maintain clinical records on all patients, assure timely referrals to and consultants with other providers, and comply with applicable State and local laws. It must be compensated for services to enrollees on a capitated basis, accept full financial risk for the services, and provide satisfactory assurances against the risk of insolvency.

(2) Provides that the CNACO must provide all covered services generally available to beneficiaries in its area, along with additional services enrollees elect to have covered. It must use Medicare-qualified providers and must make the services available and accessible with reasonable promptness and in a manner which ensures continuity of care. It must meet the same requirements as HMOs/CMPs relating to marketing, enrollment, disenrollment and grievance procedures. It must have a quality assurance program stress-

ing health outcomes and providing for professional review of health care processes.

(3) Provides for payment to a CNACO following the same principles as payment to HMOs/CMPs. The Secretary is to establish per capita payment rates for different classes of enrollees, categorized by age, disability status, and other factors. The rate for each class is set equal to 95 percent of the adjusted average per capita cost (AAPCC). The AAPCC is an estimate of what Medicare would have paid for the scope of services provided by the CNACO if enrollees had obtained the services outside the CNACO. The Secretary may not enter into a contract with a CNACO unless he determines that overall costs will not exceed what would have been spent in the absence of the contract. Provides that monthly per capita payment is issued in advance, subject to later adjustment. No other Medicare payment is made to the CNACO, any other provider, or the beneficiary for the services the CNACO covers. Payments to a CNACO are to be drawn from the Medicare part A and part B trust funds in proportions the Secretary deems equitable, taking into account the proportion of CNACO benefits attributable to the two parts.

(4) Provides that the CNACO may charge enrollees a monthly premium and/or deductibles, coinsurance, or copayments. The actuarial value of these charges may not exceed the projected average value of the Medicare coinsurance and deductibles the enrollees would have paid for the same scope of services outside the CNACO. If the CNACO offers benefits beyond those ordinarily covered by Medicare, election of coverage of the additional benefits is optional for the beneficiary. The CNACO must disclose any additional premiums or other cost-sharing amounts related to these benefits. The total additional charges cannot exceed what the CNACO would have charged comparable non-Medicare enrollees for the same set of services.

(5) Requires the Secretary to establish for each CNACO an adjusted community rate (ACR), representing an estimate of the rate the CNACO would have charged a non-Medicare enrollee for the scope of services covered by Medicare (net of deductibles and co-insurance). If the ACR is lower than the average Medicare payment rate for the CNACO, the CNACO must furnish additional benefits or reduced enrollee cost-sharing equal in value to the difference between the ACR and the average payment, or the CNACO must accept a reduction in payment rates until the ACR and average payment rate are equal. A portion of any difference between the ACR and the average payment rate may instead be deposited in a benefit stabilization fund under the provisions currently in effect for HMOs/CMPs. The Secretary may determine the average payment rate on the basis of the experience of other CNACOs if there is insufficient experience to establish an average for a particular CNACO.

(6) Requires the CNACO to make prompt payment of claims by providers of services to enrollees when those providers are not subcontractors of the CNACO. If the CNACO fails to comply, the Secretary may, after notice and an opportunity for a hearing, issue payments directly to providers and reduce the CNACO's payments accordingly. Provides that the CNACO is a secondary payer when a

workers' compensation plan or automobile or liability policy is responsible for providing benefits to an enrollee.

(7) Provides that contracts with CNACOs shall be subject to certain additional requirements presently in effect for HMOs/CMPs, including provisions relating to term of the contract, sanctions and penalties, the Secretary's right to inspect and to receive financial disclosures, and the review of quality of care by a PRO or other quality review organization.

Effective date.—

Section 9269.—Enactment.

Section 4071.—Applies to contracts entered into on or after January 1, 1988.

Senate amendment

(a) Demonstration Projects.—

Requires the Secretary to enter into agreements with at least 4 eligible organizations to conduct demonstrations of community nursing and ambulatory care services furnished on a prepaid, capitated basis. Standards for eligible organizations and operating rules for the demonstrations are comparable to those provided in section 4071 of the House bill, and are discussed below. Projects would begin no later than July 1, 1989, and would be conducted for a period of three years. The Secretary is required to report to Congress on the results of the demonstrations no later than January 1, 1992.

(b) Contracts with Community Nursing and Ambulatory Care Organizations (CNACOs).—Similar provision. Beneficiaries already enrolled in another prepaid organization are not excluded from membership. Added to the list of covered benefits are services comparable to those furnished under Medicaid home and community based waiver programs, such as case management, personal care, day care, respite care, and habilitation services, to the extent the Secretary finds such services appropriate to prevent the need for institutionalization.

(1) Similar provision. Adds an additional requirement that the site where the organization provides nursing and ambulatory care be in a health manpower shortage area as designated by the Secretary.

(2) Similar provision. Does not incorporate HMO/CMP requirements on marketing, enrollment, and disenrollment, but provides that the organization must have an annual open enrollment period. The duration of the period and other requirements relating to enrollment and disenrollment would be specific in the agreement with the organization.

(3) Similar provision. Except provides that rates for at least one of the demonstration projects would be established by the Secretary in consultation with providers, health policy experts, and consumer groups.

(4) Identical provision.

(5) Similar provision. Does not include the provision permitting the Secretary to use the experience of other organizations in projecting the average Medicare rate when there is insufficient experience for a particular organization.

(6) Identical provision.

(7)No provision.
Effective Date.—Enactment.

Conference agreement

(a) Demonstration Projects.—The conference agreement includes the Senate amendment, with modifications. The projects would be required to have protocols and procedures for timely referrals to attending physicians and other health professionals. The Secretary is authorized to require financial risk-sharing or other assurances that the projects will minimize substitution of other Medicare services for the services for which the projects are responsible, and to terminate a project failing to meet any requirements, including those relating to financial responsibility or use of institutional services.

(b) Contracts with Community Nursing and Ambulatory Care Organizations (CNACOs).—The conference agreement includes the Senate amendment.

18. Maximum Rate of Payment Per Visit for Independent Rural Health Clinics (Section 4011 of House Bill; Section 4026 of Senate Amendment).

Present law

(a) Payment Limit.—Independent rural health clinics, defined as clinics that are not part of a hospital, nursing home or home health agency, are reimbursed on the basis of an all-inclusive rate per visit. The all-inclusive rate includes all services provided by the clinic. The all-inclusive rate per visit for each facility is determined on the basis of the reasonable costs of providing the service. In determining the reasonable costs, the Secretary has established limits on the total costs per visit that may be considered reasonable. This maximum limit was set at $32.10 as of January 1, 1983.

The Medicare Economic Index (MEI) is an index of changes in physician practice costs. Unless specifically overridden by Congress, this index is the basis for limiting annual increases in physicians' prevailing charge screens under Medicare.

(b) Report to Congress.—No provision.

House bill

(a) Payment Limit.—Requires the Secretary to establish the maximum limit at $46 per visit in 1988. In subsequent years, this limit is to be increased by the percentage increase in the MEI, without reference to any legislatively determined percentage increase in the MEI that may be specified for the purpose of limiting increases in physician payments.

(b) Report to Congress.—Requires the Secretary to report to Congress by March 1, 1989 on the adequacy of the payment amounts for the services of independent rural health clinics provided under Medicare.

Effective date.—Enactment.

Senate amendment

(a) Payment Limits.—Provides that if the Secretary does not provide for an update to the current payment limit for 1988 within 120 days of enactment of this provision to reflect increases in practice

costs since the limit was last changed, the payment limit for 1988 is set at $46. Requires the Secretary to establish the maximum payment limit in years after 1988 based on the payment limit during the preceding year, increased to reflect economic data and the actual costs of furnishing rural health clinic services.

(b) Report to Congress.—No provision.

Effective date.—Applies 120 days after the date of enactment. If the Secretary updates the 1988 payment limit prior to 120 days after enactment to account for increases in practice costs since the date on which such limit was last changed, the provision specifying a $46 limit is null and void.

Conference agreement

(a) Payment limit.—The conference agreement includes the House provision.

(b) Report to Congress.—The conference agreement includes the House provision.

(e) Clarification of Penalties for Unassigned Laboratory Services.—

Section 9271.—Authorizes the Secretary to impose sanctions, either in the form of civil money penalties or exclusion from the program for up to five years, on laboratories and physicians who knowingly, willfully and repeatedly submit claims to a patient on an unassigned basis.

Section 4084.—Similar provision except that sanctions may be imposed for a single instance of billing patients on an unassigned basis.

Effective dates.—

Section 9271 applies to services performed on or after January 1, 1988.

Section 4084 applies on enactment.

(f) Moratorium on Laboratory Payment Demonstrations.—

Section 9271.—Extends the prohibition for a period of one year, until January 1, 1989.

Section 4083.—No provision.

Effective date.—Enactment.

(g) Applying Prompt-Pay Interest Requirement for Rehabilitation Facilities.—

Section 9271.—Requires interest payments to all providers reimbursed by intermediaries for clean claims not paid within certain time limits.

Section 4083.—No provision.

Effective date.—Applies to claims received on or after enactment.

(h) Treatment of Certain Comprehensive Outpatient Rehabilitation Facilties.—

Section 9271.—Provides that the Secretary may not require that CORFs certified on or before July 1, 1987 limit services to a single location so long as such services are delivered as an integrated part of a rehabilitation plan.

Requires the Secretary to monitor the provision of CORF services at multiple sites and to report to Congress not later than January 1, 1989 on the quality of off-site services provided and on whether the exception to the single site rule of CORFs certified prior to July 1, 1987 should be extended to CORFs certified after that date.

Section 4083.—No provision.

Effective date.—Enactment.

19. Adjustments in Payments for Physician Services (Section 4014 of House Bill)

Present law

(a) Increase in Prevailing Charges for Certain Physician Services.—Medicare payments for physician services are limited by prevailing charges, where the prevailing charge is defined as the lowest amount that includes 75 percent of physicians' customary charges for the same service within a locality. Notwithstanding this definition, increases in prevailing charges are limited by increases in an index known as the Medicare Economic Index (MEI). Beginning January 1, 1987, the prevailing charge for non-participating physicians is 96 percent of the prevailing charge for the same service rendered by participating physicians.

(b) Customary Charge Floor.—Customary charges are the amounts a physician usually charges for a particular service. Physicians' customary charges are estimated from historical billing data.

(c) Increases in Maximum Allowable Actual Charge (MAACs).—The MAAC limits the extent to which non-participating physicians can increase their actual charges to Medicare beneficiaries.

(d) Adjustment to MEI.—The MEI limits annual increases in prevailing charges for physician services through use of an economic index that reflects increases in physicians' practice costs.

House bill

(a) Increase in Prevailing Charges for Certain Physician Services.—Requires the Secretary to establish each year a reasonable charge floor or lower limit equal to 55 percent of the average prevailing charge for participating physicians across all localities, weighted by the frequency of the service in each locality. If the prevailing charge level in 1989 for participating physicians, as otherwise determined, is less than the reasonable charge floor, the prevailing charge level is increased by one-third of the amount by which the reasonable charge floor exceeds the prevailing charge level otherwise determined. In 1990, prevailing charges for participating physicians below the floor are increased by one-half the difference between the floor and the otherwise determined prevailing charge. In 1991, the prevailing charges for participating physicians below the floor are increased to the floor. In each of these years, the prevailing charges of non-participating physicians for services with prevailing charges below the floor would be raised to 96 percent of the increased prevailing charges of participating physicians.

(b) Customary Charge Floor.—Specifies a rule that in 1989 and 1990, for services with prevailing charges that had been increased as result of application of the prevailing charge floor, physicians' customary charges are to be set such that they are not less than the prevailing charges determined with respect to the reasonable charge floor. For these services in 1991, physicians' customary charges are set equal to the reasonable charge floor.

(c) Increases in Maximum Allowable Actual Charges (MAACs).—Provides that in 1989 and 1990 for services with prevailing charges

that had been increased as a result of application of the prevailing charge floor, the MAAC, for non-participating physicians may not be less than 96 percent of the prevailing charge for participating physicians determined with respect to the reasonable floor.

(d) Adjustment to MEI.—Provides that notwithstanding any other provision, the increase in the MEI for years after 1988 is the percentage increase determined under current law minus 2 percentage points.

Effective date.—Applies to physician services furnished on or after January 1, 1989.

Senate amendment

No provision.

Conference agreement

(a) Increase in Prevailing Charges for Certain Physician Services.—The conference agreement includes the House provision with modifications. The agreement applies only to the prevailing charges for primary care services as defined item 1. In 1989, the floor is equal to 50 percent of the average prevailing for participating physicians without regard to specialty, weighted by the frequency of the service in each locality.

(b) Customary Charge Floor.—The conference agreement does not include the House provision.

(c) Increases in Maximum Allowable Charges.—The conference agreement does not include the House provision.

(d) Adjustment to MEI.—The conference agreement does not include the House provision.

20. Coverage of Influenza Vaccine and Its Administration (Section 4021 of House Bill).

Present law

Part B of Medicare currently provides coverage for pneumococcal and hepatitis B vaccines and their administration, but does not provide coverage for influenza vaccine.

House bill

Provides for coverage of influenza vaccine and its administration.

Effective date.—Applies to influenza vaccine administered on or after January 1, 1988.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision with an amendment. The agreement provides for a contingent effective date and provides for a demonstration project and evaluation. The Secretary is required to conduct a demonstration project to test the cost-effectiveness of furnishing influenza vaccine under Medicare. The project shall begin on October 1, 1988 and continue for a period of 24 months. Not later than October 1, 1990, the Secretary shall report to Congress on the results of the project. If the Secre-

tary finds the coverage to be cost-effective, the demonstration project would be discontinued, and the provisions providing coverage for influenza vaccine would become effective on November 1, 1990. If the Secretary cannot make such a finding, the demonstration project would continue for an additional 24 months. The Secretary is required to submit a final report to Congress on the results of the study not later than April 1, 1993. The provisions providing coverage of influenza vaccine would become effective on the first day of the first month after the final report is submitted unless the Secretary finds that such coverage is not cost-effective, in which case coverage would not be effective.

The agreement specifies a spending level of $25 million per year for the demonstration project. In lieu of direct reimbursement for the cost of the vaccine, the Secretary shall arrange to provide the vaccine to be used in the demonstration project. The Secretary shall acquire the vaccine using the most cost-effective method, including purchase of the vaccine at bulk rates.

21. Coverage of Mental Health Services (Section 4024 of Senate Amendment)

Present law

(a) Outpatient Services Under Part B.—A special limit is applicable with respect to expenses incurred in a calendar year in connection with the treatment of a mental, psychoneurotic or personality disorder of an individual who is not an inpatient of a hospital at the time services are rendered. Recognized charges cannot exceed the lesser of $312.50 or 62.5% of the reasonable charges for such services. It pays 80% of the recognized amount. Thus, the maximum payment is $250 per year.

(b) Partial Hospitalization Coverage.—Medicare authorizes coverage for hospital services incident to physicians' services provided to hospital outpatients. There is no specific authorization for a partial hospitalization benefit, under which psychiatric patients can be treated in a hospital on an outpatient basis.

Under program guidelines, hospital-based distinct and organized care programs can provide care for less than 24 hours a day. In general, to be covered under Medicare, the services must be incident to a physician's service and reasonable and necessary for the diagnosis and treatment of the patient's condition.

House bill

No provision.

Senate amendment

(a) Outpatient Services Under Part B.—Increases the limit on recognized charges to $1,375 per year; thus the maximum payment is $1,100. Brief office visits (as defined by the Secretary) for the sole purpose of prescribing or monitoring prescription drugs used in the treatment of such disorders are not included for purposes of the limit.

(b) Partial Hosptialization Coverage.—

(1) Includes "partial hospitalization services incident to physicians' services within the definition of covered Part B services. Partial hospitalization services means the items and services described

under (2) prescribed by a physician and provided under a program described in (3) under the supervision of a physician pursuant to an individualized written plan of treatment established and periodically reviewed by a physician in consultation with appropriate staff participating in the program. The plan must state the physician's diagnosis; type, amount, frequency and duration of items and services provided under the plan; and treatment goals.

(2) Specifies that the items and services are: (A) individuals and group therapy with physicians, psychologists (or other mental health professionals to the extent authorized under State law); (B) occupational therapy requiring the skills of a qualified occupational therapist; (C) services of social workers, trained psychiatric nurses and other staff trained to work with psychiatric patients; (D) drugs and biologicals furnished for therapeutic purposes (which cannot be self-administered); (E) individualized activity therapies that are not primarily recreational or diversionary; (F) family counseling (the primary purpose of which is to treat the individual's condition); (G) patient training and education (to the extent that training and educational activities are closely related to the individual's care and treatment; (H) diagnostic services; and (I) such other items and services as the Secretary may provide (not including meals and transportation). These items must be reasonable and necessary for the diagnosis and treatment of the individual's condition, reasonably expected to improve or maintain the individual's condition and functional level and to prevent relapse or hospitalization. They must be furnished pursuant to such guidelines relating to frequency and duration as the Secretary may establish taking into account accepted norms of medical practice and reasonable expectation of patient improvement.

(3) Specifies that a described program is a hospital-based or hospital-affiliated program which is a distinct and organized intensive ambulatory treatment service offering less than 24-hour daily care.

(4) Requires physician certification, and recertification where such services are required over a period of time, that the individual would require inpatient psychiatric care in the absence of such services; an individualized, written plan for furnishing such services has been established and reviewed periodically by a physician, and the services are or were furnished while the patient was under a physician's care.

(5) Specifies that partial hospitalization services not directly provided by a physician are not subject to the Part B limit on outpatient mental health services.

Requires the Secretary to implement this provision so as to insure that there is no additional cost to the Medicare program.

Effective date.—(a) Applies with respect to calendar years beginning on or after January 1, 1988, (b) Enactment.

Conference agreement

(a) Outpatient Services Under Part B.—The conference agreement includes the Senate amendment with an amendment. The agreement provides for a phase-in of the benefit. In 1988, the maximum payment is increased to $450. The maximum payment is increased to $1,100 in 1989.

(b) Partial Hospitalization.—The conference agreement includes the Senate amendment with an amendment limiting application of the provision to hospital-based or hospital-affiliated providers as defined by the Secretary.

22. Coverage of Certified Nurse-Midwife Services (Section 4027 of Senate Amendment)

Present law

Medicare authorizes coverage of services, including nonphysicians services, "incident to" physicians services. The services of nonphysicians must be rendered under the physician's direct supervision by employees of the physician.

House bill

No provision.

Senate amendment

(a) Coverage.—Authorizes coverage under Part B of certified nurse-midwife services. Such services are defined as those furnished by a certified nurse-midwife, which the certified nurse midwife is legally authorized to perform under State law (or the regulatory mechanism provided by State law), whether or not the certified nurse midwife is under the supervision of, or associated with, a physician or other health care provider. A certified nurse midwife is defined as a registered nurse who has successfully completed a program of study and clinical experience, meeting guidelines established by the Secretary, and performs services in the area of management of the care of mothers and babies throughout the maternity cycle.

(b) Payment of Benefits.—Specifies that payments are to be determined on the basis of a fee schedule established by the Secretary. In no case can fee schedule amounts exceed 75% of the prevailing charge that would be allowed if the service were performed by a physician.

(c) Conforming Change.—Conforms the Medicaid definition to the Medicare definition.

Effective date.—Applies to services performed on or after July 1, 1988.

Conference agreement

(a) Coverage.—The conference agreement includes the Senate amendment with an amendment. The agreement specifies, that in cases where State law includes requirements governing physician supervision of certified nurse midwives, such requirements must be met in order for the services to be covered by Medicare. Services provided by nurse midwives may only be covered if such services would be covered if provided by a physician.

(b) Payment of Benefits.—The conference agreement includes the Senate amendment with an amendment specifying that the fee schedule amount can in no case exceed 65% of the prevailing charge that would be allowed if the service were performed by a physician. Payments for the services of certified nurse midwives can only be made on an assignment-related basis.

(c) Conforming Change.—The conference agreement includes the Senate amendment.

23. Psychologists' Services Provided in Clinics (Section 4028 of Senate Amendment)

Present law

Medicare does not currently make direct payments for psychological services delivered by a nonphysician provider except in the case of diagnostic testing services.

However, the services of psychologists employed by or providing services under arrangements with hospitals may be included within the definition of inpatient hospital services. Psychologists services may also be covered as "incident to" physicians' services provided there is direct personal supervision by a physician, and program payment is made directly to the physician.

Payment may be made under Medicare's Part B for rural health clinic services. Included in the definition of rural health clinic services are nurse practitioner and physician assistant services and incident services and supplies. The services of individuals are covered, whether or not the clinic is under the full-time direction of a physician, if the individual is legally permitted under State law to perform such services and meets training, education, and experience requirements prescribed by the Secretary.

House bill

No provision.

Senate amendment

(a) Coverage of Psychologists' Services Furnished at Rural Health Clinics.—Includes clinical psychologists in the definition of covered rural health clinic services even when such services are not provided under the supervision of a physician.

(b) Direct Payment for Psychologists' Services Furnished at a Community Health Center.—Authorizes coverage of and payments for (at an amount determined by a fee schedule established by the Secretary) "qualified psychologist services."

Defines "qualified psychologist services" as services furnished by clinical psychologist (as defined by the Secretary) at a community mental health center (as a community mental health center (as such term is used in the Public Health Service Act) which the psychologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law).

Effective date.—(a) Applies with respect to services furnished on or after the date of enactment. (b) Applies with respect to services performed on or after January 1, 1988.

Conference agreement

(a) Coverage of Psychologists' Services Furnished at a Community Mental Health Center.—The conference agreement includes the Senate amendment.

(b) Direct Payment for Psychologists' Services Furnished at a Community Mental Health Center.—The conference agreement includes the Senate amendment with an amendment specifying that payment may only be made on an assignment related basis.

24. Payments for Services of Physician Assistants (Section 4031 of Senate Amendments)

Present law

OBRA provided for Medicare reimbursement for the services of physician assistants when provided in a hospital, nursing home or as an assistant at surgery. Allowable charges are limited to specific percentages of the amount that would be allowed if the service was performed by a physician. The applicable percentages are 65 percent for assistants at surgery, 75 percent for other services provided in a hospital, and 85 percent for services provided in a nursing home.

House bill

No provision.

Senate amendment

Provides for Medicare reimbursement for the services of physician assistants in all settings. Allowable charges are limited to specified percentages of the amount that would be allowed if the service was performed by a physician. The applicable percentages are 75 percent for services provided in a hospital (other than for services provided as assistants at surgery), 85 percent for services provided in a nursing home, and 65 percent for assistants at surgery and for services provided in all other settings.

Effective date.—Applies to services furnished on or after January 1, 1988.

Conference agreement

The conference agreement includes the Senate amendment with amendments. The expansion of current coverage of services of physician assistants to all settings is limited to services provided in rural health manpower shortage areas. Allowable charges for the additional services of physician assistants provided for under this provision in rural health manpower shortage areas are limited to 85 percent of the amount that would be alllowed if the service was performed by a physician. The provision is effective Janaury 1, 1989.

25. Physician Payment Studies (Section 9270 and 4082 of the House Bill; Section 4021(j) of Senate Amendment)

Present law

(a) Report on Variations in Classifications of Procedures and Uniform Definitions of Procedures.—No provision.

(b) Expansion of Relative Value Study.—The Secretary is required to conduct a study that establishes a relative value scale that establishes a numerical relationship among various physician services. The results of this study are to be reported to Congress not later than July 1, 1989. This report is to include recommendations for the application of the relative value scale to payment of physician services rendered after December 31, 1989. The Secretary has entered into a cooperative agreement with Harvard University for the conduct of this study. Under the existing cooperative agree-

ment, the study does not encompass the services provided by all specialties under Medicare.

(c) Other Physicians Payment Studies.—

(1) The Secretary is required to conduct a study that establishes a relative value scale that establishes a numerical relationship among various physician services. The results of this study are to be reported to Congress not later than July 1, 1989. This report is to include recommendations for the application of the relative value scale to payment of physician services rendered after December 31, 1989.

(2) No provision.

(3) No provision.

(4) No provision.

(5) The Secretary is required to conduct a study that establishes a relative value scale that establishes a numerical relationship among various physician services. The results of this study are to be reported to Congress not later than July 1, 1989. As part of this report the Secretary shall develop and assess an index that can be used for making adjustments in prices to reflect justifiable differences in the costs of practice based on geographic location. The Secretary is required to develop an interim index prior to January 1, 1988 based on the most accurate and recent data with respect to the costs of practice. The Secretary is required to collect data with respect to the cost of practice for the purpose of refining the interim index prior to December 31, 1989 and for updating the index thereafter.

The Physician Payment Review Commission is required to make annual recommendations to Congress with respect to issues related to physician payments under Part B. In making its recommendations, the Commission shall consider the feasibility and desirability of reducing differences in payment amounts based to geographic variations.

(d) Study of Payment for Chemotherapy in Physicians' Offices.— No provision.

(e) Study of Prevailing Charges for Anesthesia Services.—No provision.

House bill

(a) Report on Variations in Classifications of Procedures and Uniform Definitions of Procedures.—

Section 9270.—Requires the Secretary to conduct a study and report to Congress by May 1, 1988 on variations in payment practices for physician services by the carriers processing Part B claims. The study must examine variations among carriers in the services included in global fees, and in pre- and post-operative services included in payment for an operation.

Requires the Secretary, in consultation with appropriate national medical specialty societies, to develop uniform definitions of physicians' services which could serve as the basis for payments under Part B. To the extent practicable, the definition of a service is to include ancillary services commonly performed in conjunction with a major service. Pre- and post-operative services are to be defined within the operative procedure. Similar procedures are to be combined if they are similar in resource requirements.

Section 4082.—No provision.

(b) Expansion of Relative Value Study.—

Section 9270.—Requires the Secretary to expand the current relative value scale study to include services provided by 14 additional specialties. These specialties are: cardiology, emergency medicine, gastroenterology, hematology, infectious disease, nephrology, neurology, neurosurgery, nuclear medicine, oncology, physical medicine and rehabilitation, plastic surgery, pulmonary medicine, and radiation therapy. This expansion is to be conducted such that the study in progress is not delayed. The Secretary shall report to Congress with respect to these additional specialties by not later than October 1, 1989. The Secretary shall submit to the Physician Payment Review Commission any report submitted to the Secretary pursuant to a cooperative agreement and all relevant supporting data by no later than 30 days after the report is received by the Secretary.

Section 4082.—No provision.

(c) Other Physician Payment Studies.—

Section 9270.—(1) Requires the Secretary to conduct a study of changes in the payment system that would be required to implement a national fee schedule on or after January 1, 1990. The study shall indentify major technical problems and make recommendations on ways to address such problems. The Secretary shall report to Congress on the results of this study by not later than July 1, 1989.

(2) Requires the Secretary to conduct a study if issues related to the volume and intensity of physicians' services under Part B. Issues addressed in this study must include: (1) historical trends; (2) geographic variations in volume and intensity of services; (3) an analysis of the effectiveness of current methods to ensure that payments are made only for medically necessary services; (4) development and analysis of alternative methods to control volume and intensity of services; and (5) the impact of implementation of a relative value scale on the volume and intensity of physicians' services. The Secretary shall report to Congress on the results of this study simultaneously with the relative value scale report but in no case later than July 1, 1989.

(3) Requires the Secretary to conduct a study of alternative definitions and codes for office and hospital visits, and consultations. These definitions are to assure a reliable and accurate distinction between levels of services which involve different amounts of resources, and could be recorded on claims. The Secretary shall report to Congress no later than July 1, 1989.

(4) Requires the Secretary to conduct a survey to determine the distribution of liabilities and expenditures for health care services by individuals entitled to Medicare, including liabilities for charges in excess of the reasonable charges recognized. The survey must determine the collection rates among different classes of physicians for required coinsurance amounts and for charges in excess of the reasonable charge on unassigned claims. The Secretary shall report to Congress no later than July 1, 1989.

(5) Requires the Physician Payment Review Commission to study geographic variations in reasonable or prevailing charges under Part B. The Commission shall report to Congress on the results of

the study by March 1, 1988. The report shall include recommendations for reducing geographic variations in such charges after adjustments for differences in the cost of practice and in the cost of living.

Section 4092.—No provision.

(d) Study of Payment for Chemotherapy in Physicians' Offices.—

Section 9270.—No provision.

Section 4082.—Requires the Secretary to conduct a study of ways of modifying payments under Part B of chemotherapy provided to cancer patients in physicians' offices. The study is to be performed in consultation with physicians and other health care providers who are experts in cancer therapies, and in consultation with insurers who have experience with these payment issues. The Secretary shall report to Congress no later than April 1, 1989.

(e) Study of Prevailing Charges for Anesthesia Services.—No provision.

Effective date.—

Section 9270.—Enactment.

Section 4082.—Enactment.

Senate amendment

(a) Report on Variations in Classifications of Procedures and Uniform Definitions of Procedures.—No provision.

(b) Expansion of Relative Value Study.—No provision.

(c) Other Physician Payment Studies.—No provision.

(d) Study of Payment for Chemotherapy in Physicians' Offices.—No provision.

(e) Study of Prevailing Charges for Anesthesia Services.—Requires the Secretary to conduct a study of variations in the conversion factors used by carriers to determine the prevailing charge for anesthesia services. The Secretary shall report the results of the study and make recommendations for appropriate adjustments to the converstion factors by not later than January 1, 1989.

Effective date.—Enactment.

Conference agreement

(a) Report on variations in classifications of procedures and uniform definitions of procedures.—The Conference agreement includes the House provision.

(b) Expansion of relative value study.—The conference agreement includes the House provision with an amendment that adds the following specialties to the list of 14 specialties added to the relative value study: dermatology, and physicians who specialize is osteopathic procedures.

(c) Other physician payment studies.—The conference agreement includes the House provision with an amendment.

(d) Study of payment for chemotherapy in physicians' offices.—The conference agreement includes the House provision.

(e) Study of prevailing charges for anesthesia services.—The conference agreement includes the Senate amendment.

26. Extension of Reductions Under Sequester Order (Section 4014 of Senate Amendment)

Present law

On November 20, 1987, the President issued a final sequester order pursuant to the requirements of the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987 (P.L. 100–119). Under the terms of the sequester order, Medicare benefit payments for services rendered on or after November 21 and before the end of the fiscal year are reduced by 2.324 percent, to yield an aggregate reduction in benefit payments of 2 percent over the entire fiscal year.

House bill

No provision.

Senate amendment

Provides that the reductions in Medicare payment amounts required by the final sequester order shall continue to be effective for all services through December 31, 1987. For physician, durable medical equipment and other nonphysician services reimbursed under Part B on a reasonable charge basis, the reduction amount shall continue to be effective through January 15, 1988.

Effective date.—Enactment.

Conference agreement

The conference agreement includes the Senate amendment with modification that extends the reductions in benefit payments under the sequester order for all services covered under Medicare Part B provided through March 31, 1988.

27. Miscellaneous and Technical Provisions (Sections 9271 and 4009, 4010, 4012, 4013, 4022, 4072, 4075, 4083, 4084, and 4086; Sections 4011(b), 4021 (e), (f), (g), (i), and (k), 4084, 4088, and 4090 of Senate Amendment)

Present law

(a) Prompt Submittal of Data by Secretary.—The Secretary has developed a national Part B data base known as the Part B Medicare Annual Data System (BMAD).

(b) Capacity to Set Geographic Payment Limits.—The Secretary is required to conduct a study and report to Congress on the development of a relative value scale for physician services by no later than July 1, 1989. As part of this activity, the Secretary is required to develop and assess an appropriate index for adjusting payments to reflect justifiable differences in the cost of practice and across geographic areas.

(c) Revision of Appointment Process for the Physician Payment Review Commission.—The Director of the Office of Technology Assessment (OTA) makes appointments to the Physician Payment Review Commission. The Commission is composed of individuals with expertise in the provision and financing of physician services. The Director must seek nominations from a wide range of groups including national organizations representing physicians, consumers, the elderly, medical schools, hospitals, and health benefits programs.

(d) Technical Changes in Application of Maximum Allowable Actual Charge (MAAC).—

(1) OBRA established limits known as MAACs on the actual charges that non-participating physicians can bill patients. The MAAC limits are applied to the average charge a physician may bill for a particular service during a fee screen year. That is, individual charges may exceed the MAAC so long as the average over the period does not exceed the MAAC.

(2) MAAC limits are determined separately for each non-participating physician by reference to the physician's actual charges submitted during the base period of April 1 through June 30, 1984. If a physician had no charges for a particular service during the base period, the physician's MAAC for the service is set at the 50th percentile of the customary charges of other non-participating physicians in the carrier locality.

(3) MAAC limits are determined by reference to charges submitted during the April 1 through June 30, 1984 based period.

(4) MAAC limits are determined separately for each nonparticipating physician.

(e) Clarification of Penalties for Unassigned Laboratory Services.—DEFRA established fee schedules for reimbursement of laboratory services. Services performed by independent laboratories are required to be billed on an assigned basis. COBRA required that laboratory services performed in physician's office are required to be billed on an assigned basis. No penalties were specified for instances of billing for these services on an unassigned basis.

(f) Moratorium on Laboratory Payment Demonstrations.—The Secretary is prohibited from conducting any demonstration project of competitive bidding for the payment of clinical laboratory services before January 1, 1988.

(g) Applying Prompt-Pay Interest Requirement for Rehabilitation Facilities.—Interest payments must be made by intermediaries to hospitals, nursing homes, home health agencies and hospices and by carriers to Part B physicians and providers when clean claims are not paid within certain time limits. Interest payments are not required when Part B providers are paid by intermediaries.

(h) Treatment of Certain Comprehensive Outpatient Rehabilitation Facilities.—Comprehensive outpatient rehabilitation facilities (CORFs) provide physical therapy, occupational therapy, and speech pathology services on an outpatient basis. The Secretary has required by regulation that all services be provided at a single location.

(i) Elimination of 1975 Floor for Prevailing Physician Charges.—Increases in the prevailing charges for physician service are limited by application of an economic index. If application of this index results in a prevailing charge lower than applied during the year ending June 30, 1975, the prevailing charge is increased to the level that existed during the year ending June 30, 1975.

(j) Payment for Certified Registered Nurse Anesthetists (CRNAs).—OBRA authorized direct reimbursement for the services of CRNAs beginning January 1, 1989. The Secretary is required to develop a fee schedule for these services based on audited hospital cost reports for cost reporting periods ending in fiscal year 1985. Payment for the services of a CRNA may be made to the CRNA, or

to a hospital, physician, or group practice that employs the CRNA or has a contractual relationship that provides that such entities may receive reimbursement for the CRNA's services.

(k) Clarification of Coverage of Drugs Used in Immunosuppressive Therapy.—Outpatient immunosuppressive drugs provided to a transplant patient within one year of a Medicare covered transplant procedure are a covered benefit under Part B.

(l) Revision of Part B Hearings.—Beneficiaries dissatisfied with a carrier's disposition of a Part B claim are entitled to review by the carrier. If the amount in dispute is in excess of $100, then the beneficiary has a right to a fair hearing by the carrier. The beneficiary has a right to a hearing before an administrative law judge if the amount if $500 or more, or to judicial review if the amount in dispute is $1,000 or more. National coverage determinations are subject to judicial review but not to review by an administrative law judge.

(1) Judicial review may not find national coverage determinations to be unlawful or to set them aside on the grounds that they were not published in accordance with Chapter 5, title 5 of the United States Code or with the public notice and comment requirements of the Social Security Act. Chapter 5, title 5 of the United States Code includes the Freedom of Information Act.

(2) At present, parties must exhaust all administrative review procedures before a court will accept jurisdiction.

(3) Carriers must establish and maintain procedures for conducting reviews and fair hearings of beneficiary appeals when requests for payment are denied or are not acted on promptly, or when the amount in dispute is at least $100 but not more than $500.

(m) Treatment of Employees of Physician Payment Review Commission as Congressional Employees.—The Physican Payment Review Commission was established by Congress to provide analysis and recommendations regarding Medicare physician payments policies.

(n) Change in Reporting Date for Physician Payment Review Commission.—The Physician Payment Review Commission is required to submit its recommendations regarding payments for physician services annually to Congress by March 1 of each year.

(o) Delay in Establishing a Physician Identifier System.—COBRA required the Secretary to establish and implement a system of unique identifiers for physicians providing services under Medicare not later than July 1, 1987.

(p) Assistants at Cataract Surgery.—COBRA denied Medicare payments for assistants at surgery in a cataract operation unless prior approval was obtained from an appropriate peer review organization or carrier. The PRO can approve an assistant only if warranted by the medical condition of the patient. The provision was effective April 1, 1986. The Tax Reform Act of 1986 allowed payment through December 31, 1986 if the use of an assistant was approved after surgery. PRO pre-surgery review became effective March 1, 1987.

COBRA authorized the Secretary to impose sanctions for physicians who knowingly and willfully billed the beneficiary for services for which payment could not be made.

(q) Utilization Screens for Physician Services Provided to Patients in Rehabilitation Hospitals.—Carriers are required to institute utilization safeguards to assure that payments are made for covered services that are medically necessary. Carriers use utilization screens to check for possible overutilization of services. If services are provided in excess of that level, the case is targeted for further review. The screen for physician visits to inpatients does not distinguish between visits to patients in acute care settings and those in rehabilitation settings.

(r) Collection of Past Due Amounts Owed by Physicans Who Breached Contracts Under National Health Service Corps Scholarship Program.—The National Health Service Corps provides scholarship funds for health professions training in exchange for a promise to service in a health manpower shortage area for a specified period of time (one year of service for each year of scholarship assistance received). If the physician breaches this agreement, the scholarship, plus a penalty, must be repaid.

(s) Conforming Amendment to Reporting Hospital Outpatient Information.—The Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (P.L. 95-142) required the Secretary to establish within one year of enactment uniform reporting requirements for inpatient hospitals and other providers. The Social Security Amendments of 1983 required the Secretary to maintain, at least until September 30, 1988, a system for the reporting of cost information by PPS hospitals, including information on outpatient services.

(t) Technical Amendments.—No provision.

House bill

(a) Prompt Submittal of Data by Secretary.—

Section 9271.—Requires the Secretary each year beginning in 1988 to provide national data on Part B services (BMAD system data files) to the Physician Payment Review Commission (PPRC), CBO, and CRS by October 1 of the following year. To insure data availability on a timely basis, the Secretary must require that carriers submit data for each year to the Department not later than July 1 of the following year. The Secretary is required to consult annually with the PPRC, CBO and CRS to establish and revise BMAD reporting standards. The Secretary is required to provide PPRC, CBO and CRS with such other data as may be reasonably requested. The Secretary shall develop, in consultation with the PPRC, CBO and CRS, a system for providing these entities on a quarterly basis with summary data on aggregate expenditures by type of service and provider. Such quarterly data shall be provided not later than 90 days after the end of each quarter beginning with the calendar quarter ending March 31, 1989.

Section 4083.—No provision.

Effective date.—Enactment.

(b) Capacity to Set Geographic Payment Limits.—

Section 9271.—Requires the Secretary to develop the capacity to implement geographic limits on charges and payments based on statewide, regional or national averages (or percentile in a distribution) of prevailing charges or payment amounts. The limits shall take into account differences in costs of practice and cost of living.

Section 4083.—No provision.

Effective date.—Enactment.

(c) Revision of Appointment Process for the Physician Payment Review Commission.—

Section 9271.—Provides that the Commission shall be composed of individuals with national recognition for their expertise in health economics, physician reimbursement, medical practice and other related fields. Repeals the requirement that the Director of OTA seek nominations.

Section 4083.—No provision.

Effective date.—Applies to appointments made after enactment.

(d) Technical Changes in Application of Maximum Allowable Actual Charge (MAAC).—

(1) *Section 9271.*—Provides that the MAAC limits apply to the actual charge for each service. Provides for sanctions against physicians who repeatedly violate the MAAC limit.

Section 4009.—Similar provision except that sanctions may be imposed for a single violation of the MAAC limit.

(2) *Section 9271.*—Provides that a physician without a Medicare charge for a service during the base period who can show that he had actual charges for that service prior to June 30, 1984 for either Medicare or non-Medicare patients will have his 1988 MAAC limits computed based on his actual charges for the procedure.

Section 4009.—Similar provision except that a physician without a Medicare charge for a service during the base period must show that he had charges for that service in the 12 month period ending March 31, 1984. The 1988 MAAC is then based on the actual charges during such 12 month period.

(3) *Section 9271.*—No provision.

Section 4009.—Provides that for services furnished on or after January 1, 1989, the MAAC for nonparticipating physicians is computed using a base period of the twelve months ending June 30, 1986.

(4) No provision.

Effective dates.—

Section 9271.—(1) applies to charges imposed for services provided on or after January 1, 1988. (2) applies on enactment. (3) applies to charges imposed for services furnished on or after January 1, 1989.

Section 4009.—(1) applies to charges imposed for services provided on or after January 1, 1988. (2) applies on enactment. (3) applies to charges imposed for services furnished on or after January 1, 1989.

(e) Clarification of Penalties for Unassigned Laboratory Services.—

Section 9271.—Authorizes the Secretary to impose sanctions, either in the form of civil money penalties or exclusion from the program for up to five years, on laboratories and physicians who knowingly, willfully and repeatedly submit claims to a patient on an unassigned basis.

Section 4084.—Similar provision except that sanctions may be imposed for a single instance of billing patients on an unassigned basis.

Effective dates.—

Section 9271 applies to services performed on or after January 1, 1988.

Section 4084 applies on enactment.

(f) Moratorium on Laboratory Payment Demonstrations.—

Section 9271.—Extends the prohibition for a period of one year, until January 1, 1989.

Section 4083.—No provision.

Effective date.—Enactment.

(g) Applying Prompt-Pay Interest Requirement for Rehabilitation Facilities.—

Section 9271.—Requires interest payments to all providers reimbursed by intermediaries for clean claims not paid within certain time limits.

Section 4083.—No provision.

Effective date.—Applies to claims received on or after enactment.

(h) Treatment of Certain Comprehensive Outpatient Rehabilitation Facilities.—

Section 9271.—Provides that the Secretary may not require that CORFs certified on or before July 1, 1987 limit services to a single location so long as such services are delivered as an integrated part of a rehabilitation plan.

Requires the Secretary to monitor the provision of CORF services at multiple sites and to report to Congress not later than January 1, 1989 on the quality of off-site services provided and on whether the exception to the single site rule for CORFs certified prior to July 1, 1987 should be extended to CORFs certified after that date.

Section 4083.—No provision.

Effective date.—Enactment.

(i) Elimination of 1975 Floor for Prevailing Physician Charges.—

Section 9271.—No provision.

Section 4010.—Provides that the 1975 floor on prevailing charges is eliminated.

Effective date.—Applies to payments for services rendered on or after January 1, 1988.

(j) Payment for Certified Registered Nurse Anesthetists (CRNAs).—

Section 9271.—No provision.

Section 4012.—Provides that in setting the fee schedule for CRNAs, the Secretary shall use hospital cost reports for reporting periods beginning in fiscal year 1985. Also provides that the Secretary may use other data as necessary.

Effective date.—Enactment.

(k) Clarification of Coverage of Drugs Used in Immunosuppressive Therapy.—

Section 9271.—No provision.

Section 4022.—Provides that coverage for outpatient immunosuppressive drugs under Part B includes all prescription drugs used in immunosuppressive therapy.

Effective date.—For drugs dispensed on or after enactment.

(l) Revision of Part B Hearings.—

Section 9271.—No provision.

Section 4072.—

(1) Provides that judicial review of national coverage determinations may not find the determinations unlawful or set them aside

on the grounds that they were not published in accordance with the requirements of the Administrative Procedures Act and the Social Security Act. This exemption does not include the Freedom of Information Act.

(2) Provides for expedited review of cases by an administrative law judge if the moving party alleges that there are no material issues of fact in dispute.

(3) Requires the Secretary to establish carrier performance standards for reviews and hearings. The carriers are expected to complete reviews within 45 days in 95 percent of such requests. Carriers are expected to make a final determination in 90 percent of fair hearings within 120 days of such requests.

Effective dates.—(1) applies on enactment. (2) applies to requests for hearings filed after the end of the 60 day period beginning on enactment. (3) applies to evaluations of carriers' performance under contracts entered into or renewed on or after January 1, 1988.

(m) Treatment of Employees of Physician Payment Review Commission as Congressional Employees.—

Section 9271.—No provision.

Section 4075.—Provides that for purposes of pay (other than pay for members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

Effective date.—Enactment.

(n) Change in Reporting Date for Physician Payment Review Commission.—No provision.

(o) Delay in Establishing a Physician Identifier System.—

Section 9271.—No provision.

Section 4083.—Changes the date by which the physician identifier system is required to be implemented to October 1, 1988.

Effective dates.—Enactment.

(p) Assistants at Cataract Surgery.—No provision.

(q) Utilization Screens for Physician Services Provided to Patients in Rehabilitation Hospitals.—No provision.

(r) Collection of Past Due Amounts Owed by Physicians Who Breached Contracts Under National Health Service Corps Scholarship Program.—No provision.

(s) Conforming Amendment to Reporting Hospital Outpatient Information.—Specifies that the existing reporting system is applicable only for cost reporting periods beginning prior to October 1, 1988, and establishes new specific reporting requirements for fiscal intermediaries and hospitals. Specifies that the information reported is to include outpatient visits, expenses, and revenue.

Annual reporting by each hospital.—Requires each hospital to submit information on outpatient services to the fiscal intermediary within 90 days after the end of the hospital's cost reporting period.

Effective date.—Applies to hospital cost reporting periods beginning on or after October 1, 1988.

(t) Technical Amendments.—

Section 9271.—Makes miscellaneous and technical amendments, including (1) allowing hospital to bill for clinical laboratory tests performed by other entities under certain arrangements, (2) provid-

ing that the maximum allowable actual charges of physicians who are nonparticipating but who had participated during any period on or after January 1, 1987 are computed as if the physician had been a non-participating physician for all periods after January 1, 1987, (3) providing that until the new Endstage Renal Disease network organizations established under OBRA are created, payments to existing network organization will be distributed according to the guidelines for distribution of payments in fiscal year 1986, (4) providing that incentive payments may be made to carriers if they increase the proportion of total payments that are rendered by participating physicians, and (5) providing that date by which the Secretary must report to Congress on a study to develop a strategy for quality assurance is changed from October 21, 1989 to January 1, 1990.

Section 4086.—Identical provisions except that items (1), (4), and (5) above are not included.

Effective dates.—

Section 9271.—Enactment.

Section 4086.—Enactment.

Senate Amendment

(a) Prompt Submittal of Data by Secretary.—

(b) Capacity to Set Geographic Payment Limits.—No provision.

(c) Revision of Appointment Process for the Physician Payment Review Commission.—No provision.

(d) Technical Changes in Application of Maximum Allowable Actual Charge (MAAC).—

(1) No provision.

(2) Provides that a physician without a Medicare charge for a service during the base period who can show that he had actual charges for that service during any calendar quarter during the 12 month period ending March 31, 1984 for either Medicare or non-Medicare patients will have his 1988 MAAC limits computed based on his actual charges for the procedure during the most recent calendar quarter during such 12 month period for which he had actual charges.

(1) No provision.

(4) Provides that uniform MAACs may be applied to group practices. In order to qualify for a group MAAC, the charges of physicians in a multi-specialty group must be uniform within specialty but may vary between specialties. In the case of hospital departmental practice plans, each department is treated separately.

Effective date.—April 1, 1988.

(e) Clarification of Penalties for Unassigned Laboratory Services.—No provision.

(f) Moratorium on Laboratory Payment Demonstrations.—Extends the prohibition of any competitive bidding demonstration project for a period of two years, until January 1, 1990. The Secretary may contract for the design and selections of sites for such demonstration projects.

Effective date.—Enactment.

(g) Applying Prompt-Pay Interest Requirement for Rehabilitation Facilities.—Adds comprehensive outpatient rehabilitation facilities and rehabilitation agencies to the list of providers eligible to re-

ceive prompt-pay interest for clean claims not paid within certain time limits. The Secretary is required to provide for amendments to contracts with intermediaries in order to implement the provision. This provision also states that for the purposes of the Balanced Budget and Emergency Deficit Control Act of 1987, this section is a necessary (but secondary) result of a significant policy change.

Effective date.—Applies to claims received on or after enactment.

(h) Treatment of Certain Comprehensive Outpatient Rehabilitation Facilities.—Provides that there shall be no requirement that CORFs provide physical therapy, occupational therapy or speech therapy at any fixed location so long as such services are delivered as an intergrated part of a rehabilitation plan and payments are not otherwise made under Medicare.

Effective date.—Enactment.

(i) Elimination of 1975 Floor for Prevailing Physician Charges.—No provision.

(j) Payment for Certified Registered Nurse Anesthetists (CRNAs.—Provides that in setting the fee schedule for CRNAs, the Secretary shall use hospital cost reports for reporting periods ending in fiscal year 1985, and such other data as the Secretary determines. This provision also adds ambulatory surgical centers to the list of entities that may bill and be reimbursed for the services of CRNA's when the CRNA is either employed by or has a contractual arrangement with the entity.

Effective date.—Applies as if included in the amendment in OBRA of 1986.

(k) Clarification of Coverage of Drugs Used in Immunosuppressive Therapy.—No provision.

(l) Revision of Part B Hearings.—No provision.

(m) Treatment of Employees of Physician Payment Review Commission as Congressional Employees.—No provision.

(n) Change in Reporting Date for Physician Payment Review Commission.—Changes the reporting date to May 1 each year.

Effective date.—Applies to report for years after 1987.

(o) Delay in Establishing a Physician Identifier System.—No provision.

(p) Assistants at Cataract Surgery.(1) Date for Applying Civil Penalties for Improper Use of Assistants in Performing Cataract Surgery.—Specifies that civil penalties will not apply to cases for billing for an assistant at surgery for surgeries performed prior to March 1, 1987.

(2) Assistants at Cataract Surgery.—Permits the PRO, with the concurrence of the appropriate carrier, to approve an assistant at cataract surgery if it has determined that use of an assistant is necessary to perform a surgical technique of established economic benefit (taking into account the cost of the assistant) that eliminates the need for an anesthesiologist or nurse anesthetist.

Effective date.—Effective as if included in COBRA. (b) Applies with respect to services furnished on or after the date of enactment.

(q) Utilization Screens for Physician Services Provided to Patients in Rehabilitation Hospitals.—Requires the Secretary to establish (in consultation with physician groups including those representing

rehabilitative medicine) a separate utilization screen for physician visits to patients in rehabilitative hospitals and units and patients in long-term care hospitals receiving rehabilitative services.

Requires the Secretary to take appropriate steps to implement the utilization screen within 12 months of enactment.

Effective date.—Enactment.

(r) Collection of Past Due Amounts Owed by Physicians who Breached Contracts Under National Health Service Corps Scholarship Programs.—

(1) Agreements.—(i) Adds a new Section 1891 to the Social Security Act: "Offset of Payments of Physicians to Collect Past-Due Obligations Arising From Breach of Scholarship Obligations." The Section requires the Secretary to enter into an agreement with any physician who, by reason of a breach of contract with the National Health Service Corps Scholarship Program, owes a past-due obligation to the U.S. unless that physicians has entered into a new contract pursuant to P.L. 100–177 to fulfill his original contract obligation.

(ii) Requires the agreement to provide that:

(A) Deduction are to be made from amounts otherwise payable to the physician under Medicare and Medicaid, in accordance with a schedule agreed to by the Secretary and the physician, until the past-due obligation (and accrued interest) have been repaid;

(B) Payment under Medicare to these physicians can only be made on an assignment-related basis; and

(C) If the physician does not provide a sufficient quantity of Medicare and Medicaid services to maintain the collection according to the agreement formula and schedule, or if the physician refuses to enter into an agreement or breaches any provision of the agreement, the Secretary must immediately inform the Attorney General. The Attorney General is required to immediately commence an action to recover the full amount of the past due obligation. The Secretary is required to bar the physician from Medicare and Medicaid until the entire past-due obligation has been repaid.

(D) Prohibits the Secretary from barring a physician is a sole community physician or sole source of essential specialized services in the community.

(2) Past-Due Obligation.—Specifies that a past-due obligation is any amount: (A) owed by a physician to the U.S. by reason of a breach of a National Health Service Corps scholarship contract, and (B) which has not been paid by the deadline established by the Secretay and has not been cancelled, waived, or suspended by the Secretary.

(3) Collection Not Exclusive.—Specifies that the new Section 1890 does not preclude the U.S. from applying other provisions of law otherwise applicable to the collection of obligation owed to the U.S.

(4) Collection From Providers and Health Maintenance Organizations.—(A) Requires the Secretary to deduct past-due obligations from payments to a provider, health maintenance organization (HMO) or competitive medical plan (CMP) in the case of a physician who owes a past-due obligation and is an employee of a provid-

er (which has an agreement with Medicare) or of an HMO or CMP (with a contract with Medicare).

(B) Specifies that the deduction cannot be made until 6 months after the Secretary notifies the provider, HMO or CMP of the amount to be deducted and the physicians to whom the deductions are attributable.

(C) Specifies that such deduction relieves the physician of the obligation (to the extent of the amount collected) to the U.S. The provider, HMO or CMP has a right of action to collect from the physicians the deducted amount (including accumulated interest).

(D) Specifies that no deduction shall be made if, within 6 months of the notice, the physician pays the past-due obligation or is no longer an employee of the provider, HMO or CMP.

(E) Requires the Secretary to apply these requirements in the case of a physician who is a member of a group practice if the group practice submits bills as a group.

(5) Notification to and Agreement With State Medicaid Agencies.—Requires the Secretary to notify each Medicaid agency of a physician who owes a past-due obligation. If the Physician receives (or is employed by any entity which receives) Medicaid payments, the Secretary is required to enter into an agreement with each State under which the amounts otherwise payable will be deducted as provided under (1) or (4) above. Deductions are to be made only from the Federal share of Medicaid payments. Amounts paid to the State are to be reduced accordingly.

(6) Transfer From Trust Funds.—Specifies that deducted amounts are to be transferred from the appropriate trust fund to the general fund of the Treasury and credited as payment of the named physician's past-due obligation.

(7) Medicaid Amendment.—Requires States to make deductions as specified by the Secretary under (5) above. Deductions are to be made from the Federal share of Medicaid payments and credited as payment of the named physician's past-due obligation.

(8) PHS Act Amendment.—Amends the PHS Act to provide for collection of past-due National Health Service Corps scholarship obligations through Medicare and Medicaid payments.

Effective date.—(1)–(6) Enactment. (7) applies to calendar quarters beginning after enactment, except that delay is permitted where State legislation required. (8) Enactment, except provision prohibiting discharge of obligations in bankruptcy applies with respect to contracts entered into after the date of enactment.

(s) Conforming Amendment to Reporting Hospital Outpatient Information—No provision.

(t) Technical Amendments.—No provision.

Conference Agreement

(a) Prompt submittal of data by Secretary.—The conference agreement includes the House provision.

(b) Capacity to set geographic payment limits.—The conference agreement includes the House provision.

(c) Revision of appointment process for the Physician Payment Review Commission.—The conference agreement includes the House provision with a modification to require a mix of profession-

als board geographics representation and balance between urban and rural representatives.

(d) Technical changes in application of maximum allowable actual charge.—The conference agreement includes the House provision contained in Section 9271(d).

(e) Clarification of penalties for unassigned laboratory services.—The conference agreement includes the House provision contained in Section 9271(e).

(f) Moratorium on laboratory demonstrations.—The conference agreement includes the House provision.

(g) Applying prompt-pay interest requirement for rehabilitation facilities.—The conference agreement includes the Senate amendment.

(h) Treatment of certain comprehensive outpatient rehabilitation facilities.—The conference agreement includes the Senate amendment.

(i) Elimination of 1975 floor for prevailing physician charges.—The conferenc agreement includes the House amendment.

(j) Payment for certified registered nurse anesthetists.—The conference agreement includes the Senate amendment.

(k) Clarification of coverage of drugs used in immunosuppressive therapy.—The conference agreement includes the House provision.

(l) Revision of Part B hearings.—The conference agreement includes the House provision with amendments. The effective date for the carrier performance standards for reviews and hearings applies to evaluations of carrers' performance under contracts entered into or renewed on or after July 1, 1988. The General Accounting Office is required to conduct a study of the cost-effectiveness of the current requirement for carrier hearings prior to a hearing before an administrative law judge.

(m) Treatment of Employees of Physical Payment Review Commission as Congressional Employees.—The conference agreement includes the House provision with an amendment that provides for similar treatment for employees of the Prospective Payment Assessment Commission.

(n) Change in reporting date for Physician Payment Review Commission.—The conference agreement includes the Senate amendment with an amendment setting the reporting date to March 31 of each year.

(o) Delay in establishing a physician identifier system.—The conference agreement includes the House provision.

(p) Assistants at cataract surgery.—The conference agreement includes the Senate amendment with an amendment that strikes the provision authorizing PROs to approve payment in certain cases for an assistant at cataract surgery in lieu of an anesthesiologist or nurse anesthetist.

(q) Utilization screens for physician services provided to patient in rehabilitation hospitals.—The conference agreement includes the Senate amendment.

(r) Collection of past due amounts owed by physicians who breached contracts under National Health Service Corps Scholarship program.—The conference agreement includes the Senate amendment with an amendment striking references to Medicaid.

(s) Conforming amendment to reporting hospital outpatient information.—The conference agreement includes the House provision with modifications. The existing cost reporting system is preserved indefinitely. The outpatient information requirement is included in the two State demonstration projects mandated under the hospital information reporting provisions elsewhere in this bill.

(t) Technical amendments.—The conference agreement includes the House provision.

D. PEER REVIEW ORGANIZATIONS

1. Contracts and Miscellaneous PRO Provisions (Section 9281(a), Section 4053, and Section 4054 of House bill; Sections 4041 (b), (d), (e), and (k) of Senate amendment)

Present law

(a) Contract Periods.—The Secretary contracts with private organizations (which then become peer review organizations) for the review of necessity, appropriateness, and quality of health care services furnished under Medicare. There are 54 such contracts.

The Secretary was required to enter into contracts with PROs for an initial period of 2 years, renewable every 2 years.

(b) Direct Discussion of Payment Denials with PROs.—PROs, after identifying a shortcoming in the provision of care, may take corrective action, including education, intensified review, alternate timing of review, and sanctions.

(c) Study of Effetiveness of Sending Denial Notices to Beneficiaries.—Peer review organizations are required to notify promptly the patient, and the practitioner or provider, when it makes a determination that payment should be denied under Medicare for services furnished or proposed to be furnished. This notice is required, even if the patient would not be liable to pay for the services.

(d) Contract Requirements.—Each of the 54 contracts between the Secretary and the PROs must contain certain similar elements. All of the contracts must specify objectives which are to be achieved during the contract period. These contracts must also define the structure, scope, and process of Medicare review performed by the PROs. All are expected to comply with relevant regulations and manual instructions.

The PRO contracts, however, may also contain certain differences. These differences may include different objectives, levels of preadmission review, and requirements for on-site or off-site review.

(e) Preference in Contracting with In-State Organizations.—The PRO contracts in 10 areas (Alaska, Delaware, District of Columbia, Guam/American Samoa, Idaho, Kentucky, Maine, Nebraska, South Carolina, and Vermont) are currently held by organizations based outside those areas.

(a) Contract Periods.—

Section 9281(a).—Authorizes the Secretary to extend existing PRO contracts for up to 6 months and to provide up to 2 one-year extensions of the contracts, in order to permit the Secretary an adequate time to complete contract renewal negotiations with

PROs and to provide for a staggered period of contract expiration dates.

Sections 4053 and 4054.—No provision.

(b) Direct Discussion of Payment Denials With PROs.—

Section 4053.—Provides that a PRO payment denial determination will not become final until 30 days after the date the PRO provides the physician or provider with reasonable notice of the proposed determination (including a specification of the criteria under which the determination is proposed to be made). Requires the PRO to provide the physician or provider with a reasonable and convenient opportunity during the 30-day period to discuss the proposed determination.

(c) Study of Effectiveness of Sending Denial Notices to Beneficiaries.—

Section 9281(a).—No provision.

Section 4054.—Requires the Secretary to conduct a study of the education effectiveness of PROs providing Medicare beneficiaries with payment denial notices in the instances when beneficiaries are not liable for paying for the provided services.

Requires the Secretary to report to the Congress on the results of the study by 2 years after the date of the enactment of this Act.

(d) Contract Requirements.—(1) Publication and Report Requirements.—[See Part A and B provision, "Publication of Policies"]

(2) Contractual Modifications.—No provision.

(e) Preference in Contracting with In-State Organizations.—(1) Additional Consideration.—No provision.

(2) Renewals.—No provision.

Effective date.—

Section 9281(a).—Applies to renewals occurring on or after the date of the enactment of this Act.

Section 4053.—Applies to determinations made on or after the first day of the first month that begins more than 30 days after the date of the enactment of this Act.

Section 4054.—Applies on or after the date of the enactment of this Act.

Senate amendment

(a) Contract Periods.—Provides that PRO contracts will be for an initial term of three years, renewable on a triennial basis thereafter.

(b) Direct Discussion of Payment Denials with PROs.—Prohibits a PRO from notifying the patient, fiscal intermediary, or carrier—whenever the PRO makes a determination that any health care services or items furnished or to be furnished to a patient by any practitioner or provider are disproved—until the PRO has (1) made a preliminary notification to the practitioner or provider of the determination, and (2) provided the practitioner or provider an opportunity for discussion and review of the determination.

Provides that such discussion and review will not affect the rights of a practitioner or provider to a formal reconsideration (including discussion, and where amounts in question exceed specified thresholds, hearing and judicial review).

(c) Study of Effectiveness of Sending Denial Notices to Beneficiaries.—No Provision.

(d) Contract Requirements.—

(1) Publication and Report Requirements.—Requires the Secretary to publish in the Federal Register any new policy or procedure adopted by the Secretary that affects the performance of contract obligations by 45 days before the date on which the policy or procedure is to take effect.

Requires the Secretary to publish in the Federal Register the general criteria and standards used for evaluating the efficient and effective performance of contract obligations and to provide opportunity for public comment on the criteria and standard.

Requires the Secretary to regularly furnish each peer review organization with a report that documents the performance of the organization in relation to the performance of other such organizations.

(2) Contractual Modifications.—Requires the Secretary—if a peer review organization is required to carry out a review function in addition to any function required to be carried out at the time the Secretary entered into or renewed the contract with the PRO—before requiring the PRO to carry out the additional function, to negotiate the necessary contractual modifications that provide for an appropriate adjustment (in light of the cost of the additional function) to the PRO's reimbursement.

(e) Preference in Contracting with In-State Organizations.—(1) Additional Consideration.—Requires the Secretary, if more than one qualified organization meets the specified criteria, to give additional consideration to an in-State organization. An in-State organization is defined as an organization with its primary place of business in (or which is owned by a parent corporation with its headquarters located in) the State in which the review will be conducted.

(2) Renewals.—Prohibits the Secretary from renewing a contract with any organization which is not an in-State organization unless the Secretary has first complied with the following requirements: (A) the Secretary is required to publish in the Federal Register, by 6 months before the contract period ends, the ending date and the time period in which an in-State organization may submit a proposal for that contract; and (B) the Secretary is prohibited, if one or more qualified in-State organizations submit a proposal within the period of time specified, from automatically renewing the current contract on a noncompetitive basis, and instead must provide for a competition in the same manner as for a new contract.

Effective date.—(a) Applies with respect to contracts entered into or renewed on or after the date of enactment of this Act. (b) Applies with respect to services or items furnished or to be furnished on or after the date of enactment of this Act. (d) Enactment. (e) Additional Consideration provision applies with respect to contracts entered into on or after the date of enactment of this Act. Renewals provision applies with respect to contracts scheduled to be renewed on or after the first day of the eighth month to begin after the date of enactment of this Act.

Conference Agreement

(a) Contract Periods.—The conference agreement includes the Senate amendment with a modification to allow for staggered expi-

ration dates. The Secretary is authorized to allow extensions of current contracts for up to 24 months in order to achieve the staggering.

(b) Direct Discussion of Payment Denials.—The conference agreement includes the Senate amendment with a modification to provide that a payment denial would not be effective until 20 days after the PRO has given the required preliminary notice and an opportunity for discussion and review to the practitioner or provider.

(c) Study of Denial Notices.—The conference agreement does not include the House provision.

(d) Contract Requirements.—The conference agreement includes the Senate amendment with the modification that requires the Secretary to publish in the Federal Register any new policy or procedure adopted by the Secretary that substantially affects the performance of contract obligations by 30 days before the date on which the policy or procedure is to take effect. This paragraph shall not apply to the extent it is inconsistent with a statutory deadline.

(e) Preference in Contracting with In-State Organizations.—The conference agreement includes the Senate amendment with a modification. The conference agreement does not include the requirement that the Secretary give additional consideration to an in-State organization where more than one qualified organization meets the specified criteria.

2. Beneficiary Liability (Section 9281(b) of House bill; Sections 4041 (i) and (j) of Senate amendment)

Present law

(a) Physician Services.—If a Medicare service has been determined to be medically unnecessary or of substandard quality, a peer review organization (PRO) will issue a payment denial.

Physicians may not charge beneficiaries for services which are not medically necessary. In the case of non-assigned claims, if a physician bills a beneficiary for a service before receiving a denial notice from the PRO and the beneficiary pays the bill, the physician is required to make a refund within 30 days of receiving a denial notice. If the physician appeals the PRO decision on a timely basis, repayment would not be due until 15 days after receiving notice of an adverse appeal decision. However, physicians may not charge beneficiaries for services determined by a PRO to be of substandard quality.

(b) Hospital Deductible.—Hospitals may charge beneficiaries for the inpatient hospital deductible even if Medicare payment for inpatient care has been denied by the PRO.

(c) Patient Liability for Hospital Charges During Appeal of Discharge Notice.—The Omnibus Budget Reconciliation Act of 1986 provided that a hospital may provide a patient with a coverage denial notice if the hospital determines the patient no longer requires inpatient care and if the attending physician agrees with the hospital's determination.

If the attending physician disagrees with a hospital's determination, the hospital may request the PRO to review their determination. In this situation, under current law, the patient is not provided with a denial notice.

In cases where a patient does receive a denial notice, and requests PRO review, the PRO must review the determination and provide notice to the patient, attending physician and hospital, regardless of the patient's financial liability for continued stay. If a patient requests PRO review of the hospital's determination no later than noon on the first working day after receipt of the denial notice, the hospital must furnish the PRO, by close of business that day, with the records necessary to make a determination; and the PRO must provide notice by 1 full working day after it has received the request and the records.

If a patient has made a timely request and did not know or could not reasonably be expected to know that continued stay was unnecessary, the hospital may not charge the patient for hospital services before noon of the day after the receipt of the PRO's decision.

House bill

(a) Physician Services.—Prohibits physicians, in the case of assigned claims, from billing Medicare beneficiaries for services for which payment has been denied by a PRO on substandard quality grounds.

Specifies that physicians, in the case of assigned claims which were denied on the basis of medical necessity or substandard quality, must agree to refund amounts already collected.

Specifies that physicians, in the case of non-assigned claims which were denied on the basis of substandard quality, must refund amounts already collected (unless prior to delivery of the services the patient is informed that Medicare payment will not be made and he or she agrees to pay).

Makes conforming changes to statutory language relating to settlement of claims for benefits on behalf of deceased individuals.

(b) Hospital Deductible.—Indemnifies the individual in the case of any deductible and coinsurance paid if a PRO has denied Medicare payment for services.

Provides that no item or service for which an individual is indemnified under this subsection shall be taken into account in applying any limitation on the amount of items and services for which Medicare payment may be made to or on behalf of the individual.

Effective date.—Applies to services furnished on or after January 1, 1988.

(c) Patient Liability for Hospital Charges During Appeal of Discharge Notice.—No provision.

Senate amendment

(a) Physician Services.—Similar provision, except that it requires the Secretary to provide for such timely amendments to carrier contracts and regulations, to such extent as may be necessary to implement the specified provisions, and except that it does not contain the conforming language relating to settlement of claims for benefits on behalf of deceased individuals.

Effective date.—Applies to items and services furnished on or after the date of enactment.

Hospital Deductible.—Prohibits hospitals from billing beneficiaries for any Part A deductible or copayments where the PRO has denied payments on the basis of substandards quality of service.

Effective date.—Applies to provider agreements as of the date of enactment of this Act.

(c) Patient Liability for Hospital Charges During Appeal of Discharge Notice.—Requires the PRO to notify the patient when the hospital requests review, in the case where the hospital has determined but the physician does not agree that the patient no longer requires inpatient care.

Provides that this notice shall be sufficient to require the PRO to review the validity of the hospital's determination and to require the hospital to provide the PRO with the required records.

Effective date.—Enactment.

Conference agreement

(a) Physician Services.—The conference agreement includes the House provision.

(b) Hospital Deductible.—The conference agreement includes the House provision.

(c) Patient Liability for Hospital Charges During Appeal of Discharge Notice.—The conference agreement includes the Senate amendment.

3. Norms and Education (Section 9281(c), Section 4051, and Section 4052 of the House bill; Sections 4041 (f) and (g) of the Senate Amendment)

Present Law

(a) Standards Applied by PROs.—PROs are required to apply professionally developed norms of care when reviewing the medical necessity or quality of services. Each PRO is required to develop its own norms of care.

(b) Off-Site Review.—PRO review in some instances, particularly in rural areas, is conducted off-site using written records, rather than in-person.

(c) Reports to Providers.—No provision.

(d) Education Activities.—PROs are evaluated by the HCFA regional offices, the HCFA central office and an independent contractor (known as "SuperPRO"). The Office of the Inspector General has performed audits and inspections of various aspects of the PRO program.

(e) Review of HMOs and CMPs.—The Consolidated Omnibus Budget Reconciliation Act of 1985 mandated review of services rendered by HMOs and CMPs. The Omnibus Budget Reconciliation Act of 1986 allowed the Secretary to contract for review of HMO and CMP services with entities other than PROs on a competitive basis, but such contracts are limited to no more than half of the States, covering no more than half of the total population of Medicare beneficiaries enrolled in risk-contracting plans.

HMOs and CMPs are currently reviewed for the purpose of determining whether the quality of their services meet professionally recognized standards of health care, including whether appropriate health care services have not been provided or have been provided in inappropriate settings.

(f) Psychiatric and Physical Rehabilitation Services.—The PRO, to the extend necessary and appropriate to the performance of the contract, is required to use practitioners of, or specialists in, the areas of medicine (including denistry), or other types of medical care, who, to the maximum extent practicable, are engaged in the practices of their profession within the areas served by the PRO.

(g) Telecommunications Demonstration Projects.—PROs, after identifying a shortcoming in the provision of care, may take corrective actions including education, intensified review, alternate timing of review, and sanctions.

House bill

(a) Standards Applied by PROs.—

Section 9281(c).—Requires the norms of outpatient treatment used by PROs to consider social factors (such as the distance from a patient's residence to the site of care, family support, availability of proximate alternative sites of care, and the patient's ability to carry out necessary or prescribed self-care regimens) that could adversely affect the safety or effectiveness of treatment provided on an outpatient basis.

Section 4051.—No provision.

Section 4052.—No provision.

(b) Off-Site Review.—

Section 9281(c).—No provision.

Section 4051.—Requires the PRO to publish for a visit, at least quarterly, to each rural hospital reviewed by the PRO, by the physician or physicians responsible for the review of that hospital's services. The physicians are to meet with the medical and administrative staff of the hospital regarding the PRO's review of the hospital's Medicare services.

(c) Reports to Providers.—

Section 9281(c).—Requires the PRO to publish and distribute a report, at least twice each year, to providers and practitioners subject to review, on the types of cases or clinical circumstances in which the organization has frequently determined that: (1) inappropriate or unnecessary care has been provided, (2) services were rendered in an inappropriate setting, or (3) services did not meet professionally recognized standards of health care.

Sections 4051 and 4052.—No provision.

(d) Educational Activities.—

Section 9281(c).—Requires PROs to offer to meet, at least quarterly, with medical and administrative staff of each hospital (at the hospital or at a regional meeting) about the PRO's review of the hospital's Medicare services.

Section 4052.—Requires the Secretary, when evaluating the performance of PROs to place emphasis on the performance of PROs in educating providers and practitioners (particularly in rural areas) concerning the review process and criteria being applied by the PRO.

(e) Review of HMOs and CMPs.—No provision.

(f) Psychiatric and Physical Rehabilitation Services.—No provision.

(g) Telecommunications Demonstration Projects.—No provision.

Effective date.—

Section 9281(c).—Applies to PRO contracts entered into or renewed more than 6 months after the date of the enactment of this Act.

Section 4051.—Applies to PRO contracts as of January 1, 1988.

Section 4052.—Applies to PRO contracts as of January 1, 1988.

Senate amendment

(a) Standards Applied by PROs.—Requires the PRO, in establishing norms for review purposes, to take into account the special problems associated with delivering care in remote rural areas, the availability of service alternatives to inpatient hospitalization, and social factors that can affect the safety and efficacy of service delivery.

(b) Off-Site Review.—Requires a PRO to perform at least 20 percent of its review activities of rural hospitals each year on-site and to include as part of the on-site review, on-site review at each of the rural hospitals in the PRO's area.

(c) Reports to providers.—No provision.

(d) Educational activities.—Requires the PRO to arrange for several educational sessions per year at hospitals in the PRO's area for giving providers, practitioners, and hospital personnel with the criteria used in reviewing services.

(e) Review of HMOs and CMPs.—Adds a PRO review requirement. PROs are required to determine whether HMO or CMP enrollees have adequate access to health care services provided by or through the HMO or CMP (as determined, in part, by a survey of enrollees who have not yet used the HMO or CMP for such services).

Requires each PRO contract to require a beneficiary outreach program designed to apprise individuals receiving health care provided by HMOs or CMPs of the role of the peer review system, of the rights of the individual under the system, and of the method and purposes for contacting the PRO.

(f) Psychiatric and Physical Rehabilitation Services.—Requires the PRO, to the extent necessary and appropriate to the performance of the contracts to make arrangements, in the case of psychiatric and physical rehabilitation services, to ensure that (to the extent possible) initial review of such services be made by a physician who is trained in psychiatry or physical rehabilitation (as appropriate).

(g) *Telecommunications Demonstration Projects.*—Requires the Secretary to establish demonstration projects to examine the feasibility of requiring instruction and oversight of rural physicians, in lieu of imposing sanctions, through use of video communication between rural hospitals and Medicare teaching hospitals. The Secretary may provide for payments to physicians consulted via video communications systems. No funds may be expended under the demonstration projects for the acquisition of capital items including computer hardware.

Effective date.—Applies to contracts entered into or renewed on or after the date of enactment of this Act.

Conference agreement

(a) Standards Applied by PROs.—The conference agreement includes the Senate amendment with a modification to require the PRO, in establishing norms for review purposes, to take into account other appropriate factors (such as the distance from a patient's residence to the site of care, family support, availability of proximate alternative sites of care, and the patient's ability to carry out necessary or prescribed self-care regimens) that could adversely affect the safety or effectiveness of treatment provided on an outpatient basis.

(b) Off-Site Review.—The conference agreement includes the Senate amendment with a modification to require PROs to perform significant on-site review activities including on-site review at at least 20 percent of the rural hospitals in the PROs' areas.

(c) Reports to Providers.—The conference agreement includes the House provision.

(d) Educational Activities.—The conference agreement includes Section 9281(c) of the House provision with the modification that there would be meetings several times each year instead of at least quarterly.

(e) Review of HMOs and CMPs.—The conference agreement includes the Senate amendment.

(f) Psychiatric and Physical Rehabilitation Services.—The conference agreement includes the Senate amendment.

(g) Telecommunications Demonstration Projects.—The conference agreement includes the Senate amendment.

4. PRO Sanctions (Section 4055 of House bill; Section 4041(a) of Senate amendment)

Present law

(a–c) In General.—A physician or provider who is excluded from Medicare, on the basis of a finding by a peer review organization that the physician or provider failed to furnish medical care of acceptable quality, is entitled to administrative and judicial review. That review, under current law, takes place after the exclusion takes effect.

(d) Report on Improvement in Procedures for Imposing Sanctions.—If a PRO physician reviewer identifies quality problems, and has given the attending physician an opportunity to discuss the case, the PRO must initiate corrective action, such as education, intensified review, or alternate timing of review.

If such corrective interventions do not correct

If such corrective interventions do not correct the quality problem, the PRO can initiate the sanctions process, if there is a substantial violation or a gross and flagrant violation. The Secretary is authorized to impose sanctions based on the PRO's recommendation. The Secretary may exclude from the Medicare program or impose a monetary penalty against practitioners or providers.

There are specified procedures for the sanctions process, including appeal procedures. These procedures were recently revised.

House bill

(a) In General.—Entitles a provider or pracitioner excluded from the Medicare program to a hearing before an administrative law judge to determine whether the provider or practitioner will pose a serious risk to Medicare beneficiaries if permitted to continue furnishing services during the administrative or judicial review process. If the judge does not determine, by a preponderance of the evidence, that the provider or practitioner will pose a serious risk to Medicare beneficiaries if permitted to continue furnishing services, the Secretary is prohibited from excluding the provider or practitioner from the Medicare program until after an administrative hearing on the merits of the exclusion.

(b) Transition for Current Cases.—Applies the preexclusion hearing provisions to providers or practitioners who received a notice of exclusion within 365 days before enactment, who have not exhausted the administrative remedies available to them under current law, and who request the hearing established under this provision within 90 days of enactment. For this purpose, the failure of a provider to have requested a hearing under current law on a timely basis would not be treated as having exhausted his appeal rights and would not preclude him from receiving this new hearing.

(c) Redeterminations in Certain Cases.—Requires the Secretary—If, in a hearing under (b) above, the judge does not determine, by a preponderance of the evidence, that the provider or practitioner will pose a serious risk to Medicare patients if permitted to continue or resume furnishing services—to not exclude (or suspend the exclusion, if previously made) until the provider or practitioner has had an administrative hearing, not withstanding any failure by the provider or practitioner to request the hearing on a timely basis.

(d) Report on Improvement in Procedures for Imposing Sanctions.—No provision.

Effective data.—(a) Applies to determinations made by the Secretary on or after the date of the enactment of this Act, (b) and (c) apply on or after the date of the enactment of this Act.

Senate amendment

(a) In General.—No provision.

(b) Transition for Current Cases.—No provision.

(c) Redeterminations in Certain Cases.—No provision.

(d) Report on Improvement in Procedures for Imposing Sanctions.—Requires the Secretary to report to Congress, by one year after the date of enactment, on the improved procedures for imposing sanctions against a practitioner or person, established through agreement by the Health Care Financing Administration, the American Association of Retired Persons, the American Medical Association, and the HHS Office of the Inspector General.

Requires the report to set forth the improved procedures, describe the response of physicians and providers to the procedures, assess whether the procedures effect an appropriate balance between procedural fairness and the need for ensuring quality medical care, comment on the alternative provider-patient notification procedure contained in the agreement, and recommend whether

such procedures should apply to institutional providers of health care services.

Effective date.—Applies on or after the date of enactment of this Act.

Conference agreement

(a) In General.—The conference agreement includes the House provision with a modification that it is limited to physicians practicing in rural health manpower shortage areas (HMSAs) and in counties with populations of fewer than 70,000 people.

(b) Transition for Current Cases.—The conference agreement includes the House provision.

(c) Redetermination in Certain Cases.—The conference agreement includes the House provision.

(d) Report on Improvement in Procedures for Imposing Sanctions.—The conference agreement includes the Senate amendment.

5. Separate Funding Levels (Section 4041(c) of Senate Amendment)

Present law

PROs are required not only to review inpatient hospital care, but also to review care in certain other settings, such as certain ambulatory, post-acute, health maintenance organization, and competitive medical plan settings.

The Social Security Amendments of 1983 provided that there would be a funding floor for PRO review of inpatient hospital care—expenditures in a given fiscal year (for both direct and administrative costs) were not permitted to be lower than expenditures for the program in FY 1982, adjusted for inflation. The Consolidated Omnibus Budget Reconciliation Act of 1985 changed the funding floor to the level of expenditures for the program in FY 1986, adjusted for inflation. The Omnibus Budget Reconciliation Act of 1986 provided that any additional amounts for the costs of inpatient hospital care and any amounts for the costs of other review activities are required to be funded at an amount determined by the Secretary to be sufficient to cover the costs of specified review activities.

House bill

No provision.

Senate amendment

Provides that funding for inpatient hospital review activities shall not be less in the aggregate for a fiscal year than the aggregate amount expended in fiscal year 1988 for direct and administrative costs (adjusted for inflation and for any direct or administrative costs incurred as a result of review functions added with respect to a subsequent fiscal year) of such reviews.

Provides that funding for other review activities shall not be less in the aggregate than the amounts the Secretary determines to be sufficient to cover the costs of specified review activities.

Effective date.—Applies with respect to fiscal years beginning on or after October 1, 1988.

Conference agreement

The conference agreement includes the Senate amendment.

6. Provider Representation of Medicare Beneficiaries During Appeals of Peer Review Determinations (Section 4041(h) of Senate amendment)

Present law

Any beneficiary who is entitled to Medicare benefits and who is dissatisfied with a determination made by a PRO is entitled to a reconsideration of the determination by the PRO. In certain circumstances, the beneficiary has rights to an administrative hearing and judicial review.

The Omnibus Budget Reconciliation Act of 1986 prevents the Secretary from prohibiting providers from representing beneficiaries on appeal, if the providers waive the right to payments for the appealed services.

House bill

No provision.

Senate amendment

Extends the provisions from the Omnibus Budget Reconciliation Act of 1986 to PRO reconsiderations of their determinations.

Effective date.—Enactment.

Conference agreement

The conference agreement does not include the Senate amendment.

E. Medicare and Medicaid Nursing Home Standards Reform Provisions

The conference agreement includes provisions amending the Medicare and Medicaid programs. Generally the provisions are identical. However, certain provisions apply exclusively to Medicare or Medicaid.

(1) Definition of Nursing Facilities (Section 9211(a) of Ways and Means; Section 4111(a) of Energy and Commerce; and Sections 4051(a) (1) and (2) of Senate amendment)

Present law

Under current law, in order for a skilled nursing facility to participate in the Medicare and Medicaid programs, it must meet certain requirements contained in 1861(j) of Medicare, often referred to as conditions of participation. These requirements detail standards of staffing, organization, and health and safety which SNFs must comply with in order to receive Medicare and/or Medicaid reimbursement.

At their option, Sates may also cover in their Medicaid plans intermediate care facility (ICF) services. Section 1905(c) of the Medicaid law defines an ICF as an institution which is licensed under State law to provide on a regular basis health-related care and services to individuals who do not require the degree of care and treatment provided by hospitals or SNFs but who because of their

mental or physical condition require care above the level of room and board that can be made available to them only through institutional facilities.

House bill

Section 9211(a).—Amends section 1861(j) of Medicare relating to the definition of skilled nursing facility (SNF), and requires that SNFs meet revised and expanded conditions of participation contained in a new section 1819 (described below).

Section 4111(a).—Amends the Medicaid statute by applying a single set of requirements for nursing facilities (other than intermediate care facilities for the mentally retarded). Adds a new section to the statute relating to requirements for nursing facilities (as described in (b) below).

Senate amendment

Amends section 1861(j) of Medicare to revise and expand the conditions of participation that a SNF must meet in order to participate in Medicare and/or Medicaid. Also amends Medicaid's definition of an ICF to apply certain of these revised conditions of participation to ICFs. Also provides that, for purposes of the provision of the bill requiring ICFs to meet certain of the revised conditions of participation, the term ICF includes any institution that meets the revised conditions of participation for SNFs.

Conference agreement

Conference agreement.—The conference agreement eliminates the distinction between SNFs and ICFs under the Medicaid program as of October 1, 1990.

(2) Requirements for Nursing Facilities (Section 9211(a) of Ways and Means; Section 4111(a) of Energy and Commerce; and Section 4051(a)(1) of Senate amendment)

Present law

To qualify for participation in Medicare, an institution must be a "skilled nursing facility" (SNF) as defined by Section 1961(j) of the Social Security Act. This section also lists requirements that Medicare SNFs (and by cross-reference, Medicaid SNFs) must meet. "SNF" is defined as an institution (or a distinct part of an institution) which has in effect a transfer agreement with one or more hospitals and which is primarily engaged in providing to impatients (1) skilled nursing care and related services for patients who require medical or nursing care, or (2) rehabilitation services for the rehabilitation of injured, disabled or sick persons.

The Medicaid law provides for separate requirements for ICFs. ICFs must meet (1) standards prescribed by the Secretary for the proper provision of care; (2) standards of sanitation and safety established by the Secretary in addition to those applicable to nursing homes under State law; and (3) requirements for protecting patients' personal funds.

House bill

Section 9211(a).—Defines "skilled nursing facility" to mean an institution (or a distinct part of an institution) which: (1) has a

transfer agreement with one or more hospitals under that part of the Medicare statute relating to agreements with providers: (2) is primarily engaged in providing to residents skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for the rehabilitation of injured, disabled or sick persons; and (3) meets the requirements for a SNF described in this bill relating to provisions of services, residents' rights and adminstration. Specifies that the term "skilled nursing facility" does not include any institution which is primarily for the care and treatment of mental diseases, but does include certain Christian Science SNFs, and certain institutions on Indian reservations.

Section 4111(a).—Defines "nursing facility" to mean an institution (or a distinct part of an institution) which: (1) is primarily engaged in providing to residents nursing care and related services for residents who require medical or nursing care; (2) rehabilitation services for the rehabilitation of injured, disabled or sick persons; or (3) on a regular basis, health-related care and services to individuals who because of their mental or physical condition require care and services (above the level of room and board) which can be made available to them only through institutional facilities; and (4) meets the requirements for a nursing facility relating to provision of services, residents' rights, administration and preadmission screening. Specifies that the term "nursing facility" also includes certain facilities located on certain Indian reservations.

Senate amendment

Defines the term "skilled nursing facility" to mean an institution (or a distinct part of an institution) that has in effect a transfer agreement with one or more hospitals having Medicare provider agreements and that meets the revised conditions of participation, as described here and below.

Among other things, includes in the revised conditions of participation a requirement that a SNF be primarily engaged in providing to inpatients (1) skilled nursing care and related services for patients who require medical or nursing care, or (2) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and is not primarily for the care and treatement of mental diseases.

Conference agreement

The conference agreement includes both House provisions.

(3) Requirements for Assuring Quality of Care Relating to Provision of Services (Section 9211(b) of Ways and Means; Section 4111(b), 4112 and 4113(a)(4) of Energy and Commerce; and Section 4051(a)(1) of Senate amendment)

Present law

Current Medicare and Medicaid statutes require a SNF to: (1) have policies developed with the advice of a group of professional personnel to govern the provision of services, (2) have physicians supervising the care of its residents, (3) maintain clinical records on all residents, (4) provide 24-hour nursing care, (5) provide appropriate methods and procedures for the dispensing and administer-

ing of drugs and biologicals, (6) have in effect a utilization review plan, (7) be licensed pursuant to State law, (8) have in effect an overall plan and budget, (9) cooperate in a program which provides for a regular program of independent medical evaluation and audit of the patients in the facility, (10) establish a system to prevent the commingling of resident's funds, (11) meet certain health and safety requirements, and (12) meet such other conditions relating to the health and safety of individuals furnished services in SNFs or relating to the physical facility as the Secretary may find necessary.

There are currently no nurse aide training requirements in the Medicare program. Statutory requirements are elaborated upon in regulations at 42 CFR Part 405 Subpart K. The rights of residents in regard to transfer and discharge are not defined in the Medicare statute. The regulations specify that a transfer or discharge can occur only for medical reasons and for reasons of a resident's welfare or the welfare of other residents.

Under the Medicaid staute, the Secretary is given the authority to prescribe standards for care, safety and sanitation in ICFs. They are specified in regulations at 42 CFR Part 442, Subpart F, and include requirements covering the provision of health services; the supervision of residents (for example, the facility must have a registered or practical or vocational nurse on duty full time, 7 days a week, during the day); the development and implementation of a written health plan for each resident, provide rehabilitiative and social services; provide an activities program; and provide for physician visits at least once every 60 days (with certain exceptions). The regulations also specify requirements for administration and residents' rights. There is no specific requirement for nurse aide training and testing programs, or for annual or regular resident assessments. In general, the right of ICF residents are not defined in the Medicaid statute. The regulations specify that a transfer or discharge may occur for medical reasons; for reasons of the resident's welfare or the welfare of others, and for nonpayment except as prohibited by the Medicaid program.

House bill

Section 9211(b).—

(a) Requirements Relating to Provision of Services.—Creates a new section 1819 of the Medicare Part A statute. Provides for new requirements (as described below) to be added to the section of the Medicare statute relating to provision of services.

(1) Quality of Life.—Requires a SNF to care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident. Also, see sections (2) Scope of Services under Plan of Care, and (4) Provision of Services and Activities, described below.

(2) Scope of Services under Plan of Care.—Requires a SNF to provide services that will attain or maintain the highest possible mental and psychosocial well-being, as well-as physical well-being of each resident, in accordance with a written plan of care which (A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met; and (B) is initially prepared by a team which includes the attending physician and a pro-

fessional registered nurse with responsibility for the resident, and is periodically reviewed and revised by such term after each assessment (as described below).

(3) Requirement for and Certification of Resident's Assessment.—Requires a SNF to designate appropriate qualified staff to conduct a comprehensive accurate assessment of each resident's capacity to perform daily life functions. Requires the assessment to document significant impairments in functional capacity and be based on a uniform minimum data set specified by the Secretary (as set forth in the provison of this bill relating to specification of the data set for resident assessments). Requires the assessment to be conducted or coordinated (with the appropriate participation of health professionals) by a registered professional nurse who signs and certifies the completion of the assessment. Requires that each individual who completes a portion of the assessment sign and certify as to the accuracy of that portion of the assessment.

(A) Penalty for Falsification of Resident's Assessment.—Provides that a SNF is subject to a civil money penalty of not more than $1,000 with respect to each assessment and not more than $10,000 in total, if it willfully and knowingly causes an individual to certify a material and false statement in a resident assessment. Requires the Secretary to provide for the imposition of civil money penalties in a manner similar to that for the imposition of such penalties under the current Social Secretary Act relating to the exclusion of individuals convicted of Medicare or Medicaid related crimes.

(B) Use of Independent Assessors.—Specifies that if a State determines (as a result of the survey and certification process or otherwise) that there has been a knowing and willful certification of false assessments, the SNF must provide for such assessments to be conducted and certified by individuals who are independent of the facility.

(C) Frequency of Assessment.—Requires that an assessment be conducted (i) upon admission for each individual admitted on or after Oct. 1, 1990; (ii) promptly after a significant change in the resident's physical or mental condition; and (iii) in no case less often than once every 12 months. Requires that the assessment be reviewed at least every 3 months. Requires that an assessment be conducted not later than Oct. 1, 1990 for each resident of the facility on that date.

(D) Use of Assessment.—Requires that the results of the assessment be recorded and maintained in a standard form in the clinical records of the resident and that the assessment form the basis of the planning, delivering and revising of the resident's plan of care.

(E) Coordination of Assessment.—Requires that the assessments be coordinated with any State-required preadmission screening program to the maximum extent practicable in order to avoid duplicative testing and effort.

(4) Provision of Services and Activities.—

(A) General Requirements.—Requires that to the extent needed to fulfill all plans of care described in the provision relating to scope of services, a SNF must provide, directly or under arrangements (or, with respect to dental services, under agreement) with others, for: (i) sufficient nursing, physician, and specialized rehabilitative

services to attain or maintain the highest possible physical, mental and or psychosocial well-being of each resident; (ii) medically-related social services to attain or maintain the highest possible physical, mental and psychosocial well-being of each resident; (iii) pharmaceutical services that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals to meet the needs of the resident; (iv) dietician services that assure that the meals meet the daily nutritional and special dietary needs of each resident; (v) an on-going program of activities designed to meet the interests and the physical, mental health, and psychosocial needs of each resident; and (vi) routine and emergency dental services to meet the needs of each resident. Requires that the services provided or arranged for by the SNF be of adequate quality. Specifies that (vi) does not require a SNF to provide or arrange for dental services without additional charge.

(B) Qualified Providers.—Requires that services described in (A)(i), (ii), (iii), (iv) and (vi) must be provided by qualified persons in accordance with each resident's written plan of care.

(C) Required Nursing Care.—(i) Except as provided in (D) below, requires a SNF to provide 24 hour nursing service which is sufficient to meet nursing needs of its residents and must employ the services of a registered professional nurse at least during the day tour of duty (of at least 8 hours a day) 7 days a week.

(D) Facility Waivers.—In cases in which the above provision requires that a SNF engage the services of a registered professional nurse for more than 40 hours a week, authorizes the Secretary to waive the requirement described if (1) the SNF is in a rural area and the supply of skilled nursing facility services in that area is not sufficient to meet the needs of individuals residing in that area, (2) the SNF has one full-time registered professional nurse who is regularly on duty 40 hours a week, and (3) the SNF either has only patients whose physicians have indicated that their patients do not require the services of a registered nurse or a physician for a 48-hour period, or has made arrangements for a registered professional nurse or a physician to spend such time at the SNF as may be indicated as necessary by the physician to provide needed skilled nursing services on days when the regular full-time registered professional nurse is not on duty. Requires annual renewal for the waiver.

(5) Required Training of Nurse Aides.—

(A) Training, Testing and Competency.—Requires a SNF to provide (by itself or through others) training under a training and testing program that is approved by the State under Medicare requirements (as added by this bill) for nurse aides used by the SNF, except those whom the SNF certifies have completed successfully such a program or a testing program that meets the requirements of this bill. Requires the SNF to provide an approved testing program for nurse aides employed before July 1, 1989, and such preparation as may be needed to complete successfully such a program as will permit individuals at least 2 opportunities to complete it by Jan. 1, 1990. Prohibits a SNF from first employing an individual after June 30, 1989, as a nurse aide for more than 3 months unless the individual has successfully completed a training and testing

program, or a testing program, approved by the State under Medicare requirements (as amended by this bill).

Prohibits a SNF from using an individual, first employed before July 1, 1989, as a nurse aide on or after Jan. 1, 1990, unless the individual has successfully completed an approved training and testing program, or an approved testing program. Prohibits a SNF from using an individual as a nurse aide or providing services of a type for which the individual has not demonstrated competency. Also prohibits the SNF from using such an individual as an aide unless the facility has inquired of the State registry established under this bill as to information concerning the individual's involvement in resident neglect or abuse. Provides that if the SNF uses an individual as a nurse aide and dismisses the individual because of a specific finding that the aide was involved in resident neglect or abuse, the SNF shall report this finding to the registry.

(B) Retraining.—Provides that a SNF require any individual who has ceased providing direct patient care as a nurse aide for more than 24 consecutive months to complete a training and testing program, approved by the State under Medicare requirements (as amended by this bill).

(C) On-Going Training.—Requires the SNF to have an ongoing program of training and performance review for nurse aides, including training for individuals providing special care to residents such as those with cognitive impairments.

(D) Miscellaneous.—No provision.

(E) Definition of Nurse Aide.—Defines "nurse aide" to mean any individual providing nursing or nursing-related services (whether on a full-time, temporary, per diem, or other basis) to residents in a SNF, but does not include an individual who is a physician, registered professional nurse, licensed practical nurse, licensed or certified social worker, or volunteers who provide services without monetary compensation.

(F) Definition of Licensed Health Professional.—No provision.

(6) Physician Supervision and Clinical Records.—Provides that a SNF require that the medical care of every resident be provided under the supervision of a physician; that it provide for having a physician available to furnish necessary medical care in case of an emergency; and that it maintain clinical records on all residents, which include the plan of care and the resident's assessment.

(7) Required Social Services.—Requires that SNFs provide medically-related social services to attain or maintain the highest possible physical, mental, and psychosocial well-being of each resident.

Sections 4111(b), 4112, and 4113(a)(4).—

(a) Requirements Relating to Provision of Services.—Provides for new requirements (as described below) to be included under new section 1921 of the Medicaid law relating to provision of services.

(1) Quality of Life.—Identical provision except applies to nursing facilities under Medicaid. Also, see sections (2) Scope of Services under Plan of Care, and (4) Provision of Services and Activities, described below.

(2) Scope of Services under Plan of Care.—Similar provision except requires a nursing facility to provide services and activities to attain or maintain the highest possible physical and mental health, and psychosocial well-being, of each resident in accordance

with a written plan of care which (A) is initially prepared by the attending physician or other licensed health professional with the participation of the resident or the resident's family or legal representative; (B) is periodically reviewed and revised by the attending physician or other licensed health professional after each assessment (as described below); and (C) describes the medical, nursing, mental health and psychosocial needs of the resident and how much needs will be met.

(3) Requirement for and Certification of Resident's Assessment.—Similar provision except requires a nursing facility to conduct a standardized, reproducible assessment of each resident's functional capacity through the use of an instrument which is specified by the State (under its Medicaid State plan) and which, upon completion, describes the resident's capability to perform daily life functions. Requires the registered professional nurse to sign and certify the accuracy of the assessment.

(A) Penalty for Falsification of Resident's Assessment.—Provides for a civil money penalty of not more than $1,000 for an individual who willfully and knowingly certifies a material and false statement in a resident assessment. Provides for a civil penalty of not more than $5,000 for an individual who willingly and knowingly causes another individual to certify a material and false statement in a resident assessment.

(B) Use of Independent Assessors.—No provision.

(C) Frequency of Assessment.—Similar provision except requires the assessment to be conducted not later than October 1, 1991, for each resident of the facility as of that date.

(D) Use of Assessment.—No provision.

(E) Coordination of Assessment.—No provision.

(4) Provision of Services and Activities.—

(A) General Requirements.—Similar provision, except applies to facilities under Medicaid. (i) Similar provision but requires the provision of nursing services, physicians' services, and specialized rehabilitative services to attain and maintain the highest possible physical, mental and psychosocial well-being of each resident; (ii) same provision; (iii) similar provision except specifies pharmaceutical services including procedures; (iv) same provision; (v) similar provision except specifies that the activities meet the interest and the physical and mental health and psychosocial well-being of each resident; (vi) similar provision except specifies routine and emergency dental services (to the extent covered under the State plan) to meet the needs of each resident. Requires that the services provided or arranged for by the facility must meet professional standards of quality.

(B) Qualified Providers.—Identical provision.

(C) Required Nursing Care.—(i) Requires nursing facilities to provide by Oct. 1, 1990, 24 hour licensed nursing services sufficient to meet the nursing needs of their residents and the use of a registered nurse for at least 8 consecutive hours a day, 7 days a week. (ii) Requires nursing facilities with at least 90 beds to use by Oct. 1, 1992, the services of a registered professional nurse for at least 16 hours a day, 7 days per week.

(D) Facility Waivers.—Provides waivers for (i) the 24-hour licensed nursing requirement for facilities with less than 90 beds

and designated as ICFs; (ii) the registered nurse requirement over the week-end for certain facilities; and (iii) the second shift registered nurse requirement for certain larger nursing facilities in rural areas. For certain facilities currently designated as ICFs, allows the Secretary to delay the staffing requirements upon the request of a State with more ICFs than SNFs, and if the Secretary determines that compliance is impracticable. States qualifying for this waiver would not have to bring their ICFs into compliance with the nursing staff requirements until Oct. 1, 1991, and for small ICFs, until Oct. 1, 1992. Furthermore, States qualifying for a waiver of additional RN care for large ICFs would not have to bring these facilities into compliance until Oct. 1, 1993.

Provides that the Secretary may grant waivers only upon the request of a State on behalf of a facility and only for a period of up to six months. Provides that waivers may be renewed upon the request of a State and only for additional periods not to exceed six months.

(5) Required Training of Nurse Aides.—

(A) Training, Testing and Competency.—Prohibits a facility from employing an individual, who is not a licensed health professional (as defined below), as a nurse aide on or after Jan. 1, 1990 unless the individual: (i) is competent to provide such services as a result of completing a training program recognized and approved by the State (under Medicaid requirements as amended by this bill) or (ii) is enrolled in, and making timely progress in completing, such a training program, the completion of which assures that the individual is competent to provide such services, and with respect to providing specific nursing or nursing-related services, is competent to provide those services.

(B) Retraining.—Similar provision except specifies that the individual is not considered to have completed a training program if there has been a continuous period of 24 consecutive months since completing the program during which the individual did not perform nursing or nursing-related services for compensation.

(C) On-Going Training.—Requires a nursing facility to provide such regular performance review and regular in-service education as assures that an individual used as a nurse aide is competent to provide those services.

(D) Miscellaneous.—No provision.

(E) Definition of Nurse Aide.—Similar provision, except does not include volunteers in the list of professionals who are not nurse aides.

(F) Definition of Licensed Health Professional.—Defines licensed health professional as a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapist, registered professional nurse, licensed practical nurse, or licensed social worker.

(6) Physician Supervision and Clinical Records.—Similar provision except applies to nursing facilities under Medicaid and requires that the health care of the facility of every resident be provided under the supervision of a physician.

(7) Required Social Services.—Requires that a nursing facility with more than 120 beds have at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications) employed full-time to provide or assure the provision

of social services. Also requires that nursing facilities provide medically-related social services to attain or maintain the highest possible physical, mental, and psychosocial well-being of each resident.

(a) Requirements Relating to Provision of Services.—Revises and expands existing conditions of participation and requirements for SNFs. Also requires that ICFs meet certain of these revised conditions.

(1) Quality of Life.—Identical provision, except applies to SNFs and ICFs. Also requires institutions to meet the needs of each resident for necessary medical, nursing, restorative, and psychosocial services that permit the resident to attain and maintain the highest feasible level of functioning in the least restrictive environment possible in light of his or her condition.

Further requires the institution to maintain a quality assessment and assurance program that meets the following requirements:

(A) A committee, consisting, of the director of nursing services, a physican designated by the institution, and at least 3 other members of the staff, meets at least quarterly to identify issues for which quality assessment and assurance activities are necessary.

(B) One member of this committee is assigned primary responsibility for ongoing coordination and oversight of quality assessment and assurance activities.

(C) The committee seeks comments and suggestions from residents and staff on quality assessment and assurance issues (and maintains a permanent record of the comments and suggestions received).

(D) Issues addressed by the committee at least annually shall include: (1) prevention measures and the occurance of infectious diseases; (2) the promotion of behavioral, cognitive, and social functioning; (3) quality of life; (4) use of medications (including a review of each resident's drug regimen); (5) use of chemical and physical restraints; (6) appropriations, adequacy, and implementation of nursing plans; (7) frequency and seriousness of accident reports (and measures for preventing accidents); and (8) frequency and resolution of residents' grievances and compliants (and mechanisms for monitoring the satisfaction of residents with the quality of care.

(E) The committee develops and implements appropriate plans of action to correct identified quality deficiencies.

(F) The committee (1) documents the time expended by it in quality assessment and assurance activities and the issues that it has addressed, and (2) makes such documentation available, upon request, to the Secretary and to the appropriate agency resonsible for conducting certification surveys of the institution.

(G) The confidentiality of the committee records must be maintained, except to the extent the committee must make such documentation available to the Secretary and survey agency.

(H) In determining whether an institution complies with these requirements, the Secretary and the appropriate State survey agency shall take into account the degree to which the committee identified and acted upon any deficiencies found in the institution.

(2) Scope of Services under Plan of Care.—Requires a SNF to provide services to maintain or improve each resident's mental and psychosocial well-being, as well as physical well-being, in accordance with a written plan of care which (A) is developed, to the

extent practicable, in consultation with the resident (or his or her legal representative) and by a multidisciplinary team coordinated by a registered professional nurse, (B) is periodically reviewed and revised after each assessment (as described below), and (C) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met.

Also requires SNFs and ICFs to provide for an activities program, directed by a qualified professional, to encourage selfcare, resumption of normal activities, and maintenance of an optimal level of psychosocial functioning in a manner appropriate to the needs and interests of each resident.

(3) Requirement for and Certification of Resident's Assessment.—Requires that SNFs and ICFs provide for each patient accurate assessments that include (but not be limited to) the identification of medical problems and the assessment of physical, mental, and psychosocial functioning. Requires that the assessment utilize a minimum data set of core elements and common definitions and guidelines for utilization specified by the Secretary (in accordance with guidelines established by the Secretary). Also requires that the assessment be coordinated by a registered professional nurse and carried out in consultation with appropriate health care providers (such as licensed practical nurses, nursing aides, activities professionals, social workers, pharmacists, nutritionists, mental health professionals, and rehabilitation therapists). Further requires that the assessment be available for review and comment by the resident in accordance with the resident's right to participate in developing his or her plan of care.

(A) Penalty for Falsification of Resident's Assessment.—No provision.

(B) Use of Independent Assessors.—No provision.

(C) Frequency of Assessment.—Requires a preliminary assessment of each resident within 48 hours of admission. Also requires a comprehensive assessment of each resident within 21 days of admission, at least annually thereafter, and whenever there is a significant change in the resident's mental or physical condition.

(D) Use of Assessment.—Requires that the result of the assessment be recorded in the clinical records of the resident and be used in formulating, reviewing, and revising the resident's plan of care.

(E) Coordination of Assessment.—Requires that the preliminary assessment be coordinated with any State-required preadmission screening to the maximum extent practicable in order to avoid duplicative testing and effort.

(4) Provision of Services and Activities.—

(A) General Requirements.—Requires that staffing of SNFs and ICFs be at a level to meet the needs of its residents. Requires that an institution's compliance with this requirement be determined by the survey and certification process and not by any reports required to be filed by the institution on a quarterly or other periodic basis. Prohibits the Secretary or State from requiring an institution to submit a quarterly staffing report on or after the date of enactment of the bill.

Also requires that a SNF establish appropriate methods and procedures for the dispensing and administering of drugs and biologicals.

(B) Qualified providers.—No provision.

(C) Required Nursing Care.—Except as provided in (D) below, requires SNFs and IDFs to provide 24-hour licensed nursing service that is sufficient to meet nursing needs in accordance with the policies of the institution and to have at least one registered professional nurse employed full-time.

(D) Facility Waivers.—Authorizes a State to waive the licensed nursing care requirement if: (1) the institution demonstrates to the State's satisfaction that it has been unable, despite diligent efforts (including offering wages at the community prevailing rate), to recruit appropriate personnel, and (2) the State determines that a waiver will not endanger the health and safety of individuals staying in the institution. Requires that a waiver be subject to annual renewal and to review by the Secretary (under the Secretary's authority to conduct validation surveys) and shall be accepted by the Secretary to the same extent as is the State's certification of the institution.

(5) Required Training of Nurse Aides.—

(A) Training, Testing and Competency.—Requires a SNF and ICF (by itself or through others) to provide training for individuals hired or utilized as nurse aides under a program that is approved by the State. Applies this requirement to individuals hired on or after Jan. 1, 1990. Prohibits a SNF or ICF from employing or utilizing any individual as a nurse aide for more than 6 months unless the individual has successfully completed a training and competency evaluation program that is recognized and approved by the State. Prohibits a SNF and ICF from employing an individual, hired before Jan. 1, 1990, as a nurse aide on or after the date that is 3 years after enactment unless the individual has successfully completed an approved competency evaluation program. Requires institutions to provide these individuals at least three opportunities to complete the program and the preparation necessary for successful completion.

Prohibits institutions from permitting any nurse aide to provide unsupervised patient care of a type for which the aide has not demonstrated competency.

(B) Retraining.—Similar provision except (1) specifies that the individual complete an "appropriate" training and competency evaluation program; and (2) does not specify that the period is 24 "consecutive" months.

(C) On-Going Training.—Identical to Ways and Means provision.

(D) Miscellaneous.—Requires SNFs and ICFs to provide each new nurse aide an orientation to the facility and to the residents for whom the aide provides care (in addition to the general initial training and competency testing program).

Also requires institutions to assure that all aides are able to read, speak, and write sufficiently to perform assigned duties.

(E) Definition of Nurse Aide.—No provision.

(F) Definition of Licensed Health Professional.—No provision.

(6) Physician Supervision and Clinical Records.—Requires for SNFs that the health care of every resident be provided under the supervision of a physician and that a physician be available to furnish necessary medical care in case of emergency. Also requires

SNFs and ICFs to maintain clinical records (on a discipline-specific or interdisciplinary basis) on all residents.

(7) Required Social Services.—Requires that a SNF or ICF with more than 120 beds have at least one social worker (with at least a bachelor's degree in social work) employed full-time. Authorizes the Secretary to waive this requirement if: (1) the institution demonstrates to the Secretary's satisfaction that it has been unable, despite diligent efforts (including offering wages at the community prevailing rate), to recruit appropriate personnel, and (2) the Secretary determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the institution. Requires that a waiver be subject to annual renewal.

Conference agreement

The conference agreement includes both House provisions with an amendment incorporating Senate provisions:

(1) to require facilities to maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and develops and implements appropriate plans of action to correct identified quality deficiencies;

(2) to require that written plans of care be initially prepared, to the extent practicable, with the participation of the resident or the resident's family or legal representative;

(3) to require that the residents' assessments include the identification of medical problems;

(4) to require the on-going program of activities to be directed by a qualified professional;

(5) to require nurse aides to have completed a training and competency evaluation (instead of testing) program, or a competency evaluation (instead of testing) program. The conferees struck the term "testing" and replaced it with the words "competency evaluation" to emphasize that such programs shall include manual and oral evaluation; and

(6) to require facilities with more than 120 beds to employ full-time at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications).

The conference agreement retains Medicare's current law nurse staffing and registered professional nurse (RN) requirements and waiver provisions applying to the RN requirement. For Medicaid, the conference agreement requires as of October 1, 1990, that all SNFs and ICFs, in urban and rural areas, provide 24-hour licensed practical nurse (LPN) care 7 days a week, with at least one RN employed 7 days a week, 8 hours a day. The conference agreement authorizes States to waive the RN and LPN requirements if (1) the institution demonstrates to the satisfaction of the State that it has been unable, despite diligent efforts (including offering wages at the prevailing rates at other nursing facilities), to recruit appropriate personnel, and (2) the State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the institution. The conference agreement also author-

izes the Secretary to exercise States' authority to grant such waivers if the Secretary finds, based on a clear pattern and practice of allowing waivers in the absence of diligent efforts, that a State had abused its discretion.

The conference agreement also requires facilities, in the provision defining scope of services, to provide services to attain or maintain the highest practicable physical, mental, and psychological well-being of each resident.

In addition, the conference agreement includes, in the resident assessment requirements that facilities participating in Medicaid must meet, preadmission screening requirements for mentally ill and mentally retarded individuals.

(4) Requirements Relating to Residents' Rights (Section 9211(b) of Ways and Means; Section, section 4111(c) of Energy and Commerce; and Sections 4051(a) (1), (2), and (4) and 4051(e) of Senate amendment)

House bill

Section 9211(b).—

(a) General Description.—Amends the Medicare statute relating to SNFs to include residents' rights as specified below. Requires that a SNF protect and promote these rights, including each of the following specific rights.

(b) General Rights.—

(1) Specified Rights.—

(A) Free Choice.—Provides for the right to choose a personal attending physician, to be fully informed in advance about care and treatment, to participate, where appropriate, in planning care and treatment, and to be fully informed in advance of any changes in care or treatment that may affect the resident's well being.

(B) Free from Restraints.—Provides that a resident has the right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Restraints may only be imposed to ensure the physical safety of the resident or other residents and only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used, except in emergency circumstances, specified by the Secretary, until such a physician order can reasonably be obtained.

(C) Privacy.—Provides that a resident has the right to privacy with regard to accommodations, medical treatment, and written and telephonic communications. Specifies that this does not mean that the facility is required to provide a private room.

(D) Confidentiality.—Provides that a resident has the right to confidentiality of personal and clinical records.

(E) Accommodation of Needs.—Provides that a resident has the right to reside and receive services with reasonable accommodations of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered, and to receive notice before the room or roommate of the resident is changed.

(F) Grievances.—Provides that a resident has the right to voice grievances with respect to treatment or care that is (or fails to be)

furnished, without discrimination or reprisal for voicing the grievances and the right to resolution promptly by the facility of grievances the resident may have with respect to the behavior of other residents.

(G) Participation in Resident and Family Groups.—No provision.

(2) Notice of Rights and Services.—Requires a SNF to: (A) tell each resident of his or her legal rights during the stay at the facility; (B) provide to each resident, upon reasonable request, a written statement of such rights (which statement is updated upon changes in such rights); and (C) inform each resident, in writing before or at the time of admission and periodically during the resident's stay, of rights and of services available in the facility and or related charges for such services, including any charges for services not covered under Medicare or Medicaid, or not covered by the facility's basic per diem rate.

(3) Rights of Incompetent Residents.—Requires that in a case of a resident adjudged to be incompetent under State law, for the rights of the resident described in this provision to devolve upon, and be exercised by, the person appointed under State law to act on the resident's behalf.

(4) Use of Psychotropic Drugs.—No provision.

(c) Transfer and Discharge Rights.—

(1) In General.—Prohibits a SNF from involuntarily transferring or discharging a resident unless: (A) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility; (B) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) the safety of individuals in the facility is endangered; (D) the health of individuals in the facility would otherwise be endangered; (E) the resident has failed, after reasonable and appropriate notice, to pay (or to have Medicare pay on the resident's behalf) an allowable charge imposed by the facility for an item or service requested by the resident and for which a charge may be imposed consistent with the Medicare statute; or (F) the facility ceases to operate or participate in the program which reimburses for the resident's care. Requires for (A) through (D) that the transfer or discharge be documented by the resident's physician in the resident's clinical record.

(2) Pre-Transfer and Pre-Discharge Notice.—(A) Requires that before effecting an involuntary transfer or discharge of a resident a SNF must: notify the resident (and the guardian or an immediate relative of the resident, if known) of the transfer or discharge and the reasons; record the reasons in the resident's clinical record (including required documentation); and provide timely notice including certain required information. (B) Requires that the notice be provided at least 30 days in advance of a resident's transfer or discharge except when the safety or health of individuals in the facility are endangered or where the resident's health improves sufficiently to allow a more immediate transfer or discharge, or where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs. (C) Requires each notice to include for transfers or discharges on or after Oct. 1, 1989, notice of the resident's right to appeal the transfer or discharge as provided under

the Medicare statute as amended by this bill, and the name, mailing address and telephone number of the State long-term care ombudsman.

(3) Orientation.—Requires a SNF to provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(4) Notice on Bed-Hold Policy and Readmission.—No provision.

(d) Access and Visitation Rights.—Requires a SNF to: (1) permit immediate access to any resident by officially designated representatives of the Secretary or the State, by officially designated ombudsman, or by the resident's individual physician; (2) permit immediate access to a resident, subject to the resident's right to deny or withdraw consent at any time, by immediate family or other relatives of the resident; (3) permit immediate access to a resident, subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, by others who are visiting with the consent of the resident; (4) permit reasonable access to a resident by any entity or individual that provides health, social, legal or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (5) permit representatives of the State ombusdsman, with the permission of the resident (or the resident's legal representative) and consistent with State law, to examine a resident's medical, nursing, and social records.

(e) Equal Access to Quality Care.—

(1) General Application.—Requires a SNF to establish and maintain identical policies and practices regarding transfer, discharge, and covered services for all individuals regardless of source of payment.

(2) *Admissions.*—(A) *In General.*—Prohibits a SNF from requiring individuals applying to reside or residing in the facility to waive their rights to benefits under Medicare or Medicaid. Prohibits a SNF from requiring oral or written assurance that such individuals are not eligible for, or will not apply for, Medicare or Medicaid benefits. Requires the SNF to prominently display in the facility and provide to such individuals written information about how to apply for and use such benefits and how to receive refunds for previous payments covered by Medicare or Medicaid. Also prohibits a SNF from requiring a third party guarantee of payment to the facility as a condition of admission to, or continued stay in, the facility.

(B) Construction.—Specifies that the admissions provision above does not prevent States or political subdivisions of States from prohibiting discrimination against individuals who are entitled to Medicaid with respect to admissions practices of skilled nursing facilities. Provides that it also does not prevent a facility from requiring an individual, who has legal access to a resident's income or resources available to pay for care of the facility, to sign a contract (without incurring personal financial liability) to provide payment from the resident's income or resources for such care.

(f) Protection of Resident Funds.—(1) Requires a SNF, upon written authorization by a resident, to accept responsibility for holding, safeguarding, and accounting for the resident's personal funds, and providing each resident access to such funds and records of such funds. (2) Requires the SNF to establish and maintain a system that assures a full and complete accounting (not less often than

quarterly) of each resident's personal funds, and that establishes a separate account or accounts for such funds in order to prevent any commingling of such funds with institutional funds or with the funds of any person other than another resident. (3) Requires that upon a resident's death, the SNF promptly convey the resident's personal funds (and a final accounting of the funds) to the individual administering the resident's estate.

(g) Right to Examine Results of Survey.—No provision.

Section 4111(c).—

(a) General Description.—Similar provision except applies to requirements for nursing facilities under Medicaid.

(b) General Rights.—

(1) Specified Rights.—

(A) Free Choice.—Provides that a resident has the right to choose a personal attending physician, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

(B) Free from Restraints.—Similar provision, except does not specifically provide for the use of restraints to treat for medical symptoms or their use in emergency circumstances.

(C) Privacy.—Similar provision except adds that a resident has the right to privacy with regard to visits, and meetings of family and of resident groups.

(D) Confidentiality.—Identical provision.

(E) Accommodation of Needs.—Provides that a resident has the right to reside and receive services in the least restrictive environment, except where the health and safety of the individual or other residents would be endangered.

(F) Grievances.—Provides that a resident has the right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances.

(G) Participation in Resident and Family Groups.—Provides that a resident has the right to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.

(2) Notice of Rights and Services.—Requires a nursing facility to: (A) provide to each resident, upon reasonable request, a written statement of the resident's legal rights during the stay at the facility (which is updated upon changes in such rights); (B) inform each resident who is entitled to medical assistance under Medicaid at the time of admission to the facility or, if later, at the time the resident becomes eligible for Medicaid, of the items and services that are included in the nursing facility services under Medicaid and for which the resident may not be charged (except as permitted under the Medicaid statute), and of those other items and services that the facility provides and for which the resident may be charged and the amount of the charges for such items and services. Also requires that the nursing facility inform each Medicaid resident of changes in the charges imposed for items and services; (C) inform in writing residents not entitled to Medicaid, before or at the time of admission and periodically during the resident's stay, of

services available in the facility and or related charges for such services, including any charges for services not covered by the facility's basic per diem charge; and (D) upon admission, provide to each resident and each resident's spouse (if any) the written notice of the resident's and spouse's obligations. (The notice is to be developed and distributed by the State under Medicaid requirements of the State created by this bill.)

(3) Rights of Incompetent Residents.—Similar provision. Requires that for a resident adjudged incompetent under the laws of a State, the rights of the resident under this provision to be devolved upon, and to the extent judged necessary by a court of competent jurisdiction, be exercised by the person appointed under State law to act on the resident's behalf.

(4) Use of Psychotropic Drugs.—Requires that psychotropic drugs be administered only on physician orders and only as part of a plan included in the written plan of care designed to eliminate or modify symptoms for which the drugs are prescribed and only if, at least annually, an independent consultant in psychopharmacology review the appropriateness of the drug plan of each resident receiving such drugs.

(c) Transfer and Discharge Rights.—

(1) In General.—Similar provision, except applies to nursing facilities under Medicaid. Requires that for the cases described in (A) through (D) that the basis for the transfer or discharge be documented in the resident's clinical record. Requires for the cases described in (A) and (B) that documentation be made by the resident's physician. If a transfer or discharge occurs as a result of a resident failing to pay or to have paid an allowable charge imposed by the facility for an item or service requested by the resident and provided by the facility, and if the resident has become eligible for assistance under Medicaid after admission to the facility, only charges which may be imposed under Medicaid are to be considered allowable.

(2) Pre-Transfer and Pre-Discharge Notice.—(A) Similar provision except applies to nursing facilities under Medicaid. Requires the facility to notify the resident (and an immediate family member of the resident or legal representative) of the transfer or discharge and the reasons for it. (B) Similar provision except includes under the list of exceptions to the 30 day rule a case where a resident has not resided in the facility for 30 days. Requires that in the case of such exceptions that notice must be given as many days before the date of the transfer or discharge as is practicable. (C) Similar provision except provides that notice be given of a resident's right to appeal the transfer or discharge as provided under the State process established under this legislation.

Requires that, in the case of residents with developmental disabilities, the notice include the address and telephone number of the agency responsible for the protection and advocacy system for developmentally disabled individuals established under the Developmental Disabilities Assistance and Bill of Rights Act. Requires that in the case of mentally ill residents, the notice include the address and phone number of the responsible agency for the protection and advocacy system for such persons established under the Protection and Advocacy for Mentally Ill Individuals Act.

(3) Orientation.—Identical provision, except applies to nursing facilities under Medicaid.

(4) Notice on Bed-Hold Policy and Readmission.—

(A) Requires that before a resident is transferred for hospitalization or therapeutic leave, a nursing facility must provide written information to the resident and an immediate family member or legal representative concerning the provisions of the State plan under Medicaid regarding the period (if any) during which the resident will be permitted to return and resume residence in the facility, and the policies of the facility regarding such a period. These policies are required to be consistent with the provisions of (C) below.

(B) Requires that at the time of transfer of a resident to a hospital or therapeutic leave, a facility must provide written notice to the resident and an immediate family member or legal representative of the duration of any period described in (A) above.

(C) Requires a nursing facility to establish and follow a written policy under which a resident eligible for medical assistance for nursing facility services under Medicaid, who is transferred from the facility for hospitalization or therapeutic leave, and whose hospitalization or therapeutic leave exceeds a period paid for under Medicaid for the holding of a bed for the resident, will be permitted to be readmitted to the facility immediately upon the first availability of a bed in a semiprivate room in the facility if, at the time of readmission, the resident requires the services provided by the facility.

(D) No provision.

(d) Access and Visitation Rights.—Requires a nursing facility to: (1) similar, except does not specify that the representatives be officially designated; (2) permit immediate access to a resident, subject to the resident's right to deny or withdraw consent at any time, by members of the immediate family of the resident; (3) permit immediate access to a resident (subject only to reasonable restrictions) by relatives (other than immediate family members) of the resident and others wo are visiting with the consent of the resident; (4) permit reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident; (5) similar provision except limits the State ombudsman to examine a resident's clinical records.

(e) Equal Acces to Quality Care.—

(1) General Application.—Simiar provison except applies to nursing facilities under Medicaid, and the services of those facilities under the State plan. Specifies that this does not prevent a facility from charging for services furnished, consistent with the notice to residents required under this bill. Specifies that it also does not require a State to offer additional services on behalf of a resident than are otherwise provided under Medicaid.

(2) Admissions.—

(A) General.—Similar provision except specifies that the facility provide oral and written information about how to apply for and use the benefits and how to receive refunds for previous payments covered by such benefits. Also prohibits a facility from requiring a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the fa-

cility. For residents entitled to medicaid assistance, prohibits a facility from charging, soliciting, accepting or receiving (with the exception of amounts otherwise required to be paid under the State plan) any gift, money, donation or other consideration as a precondition of admitting (or expediting the admission of) the individual to the facility or as a requirement for the individual's continued stay in the facility.

(B) Construction.—Similar provision except applies to admissions practices of nursing facilities under Medicaid. Also specifies that the admissions provisions does not prevent a facility from charging a resident, eligible for Medicaid, for items or services the resident has requested and received and are not specified in the State plan as included in the term "nursing facility services." Provides that it also does not prevent a nursing facility from soliciting, accepting, or receiving a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the resident (or potential resident), but only to the extent that such contribution is not a condition of admission, expediting admission or continued stay in the facility.

(f) Protection of Resident Funds.—(1) Similar provision except applies to nursing facilities under Medicaid. (2) Requires that where a resident has given the authorization under (1) above, that the nursing facility establish and maintain a system that assures full and complete accounting of each resident's personal funds, and establishes a separate account for such funds in order to prevent any commingling of such funds with institutional funds or with the funds of any other person other than another such resident, and notifies each resident receiving Medicaid when the amount in the resident's account reaches $200 less than the qualifying dollar amount that may result in the loss of Medicaid eligibility (under SSI) and the fact that if the amount in the account (in addition to the value of the resident's other nonexempt resources) reaches that amount, the resident may lose eligibility for medical assistance. (3) Identical provision.

(g) Right to Examine Results of Survey.—No provision.

Senate amendment

(a) General Description.—Requires SNFs and ICFs to protect and promote the rights of individuals residing in the institution, including each of the rights described below, and any other right established by the Secretary.

(b) General Rights.—

(1) Specified Rights.—

(A) Free Choice.—No provision.

(B) Free from Restraints.—No provision.

(C) Privacy.—Provides residents of SNFs and ICFs with the right to associate and communicate privately with persons of their choice.

(D) Confidentiality.—No provision.

(E) Accommodation of Needs.—No provision.

(F) Grievances.—Provides that residents of SNFs and ICFs have a right to prompt efforts by the institution to resolve grievances the individual may have, including those with respect to the behavior of other residents. Also provides the right to file complaints, voice

grievances, and recommend changes in policies and service to the staff of the facility and to outside representatives of the resident's choice, free from restraint, interference, coercion, discrimination, or reprisal.

(G) Participation in Resident and Family Groups.—Provides that residents of SNFs and ICFs have the right (with those of family members) to organize, maintain, and participate in resident advisory and family councils, including the right to assistance from a designated staff member, space, and privacy for meetings. Also provides residents with the right to participate freely in social, religious, and community activities that do not interfere with the rights of others residing in the facility.

(2) Notice of Rights and Services.—Provides that residents of SNFs and ICFs have the right (A) to be informed orally and in writing at the time of admission to the institution of the resident's legal rights during the stay at the facility and to have these rights described in a written statement, which is made available to the resident upon reasonable request and which is updated upon changes in rights; (B) to be informed in writing before or at the time of admission and periodically during his or her stay of services available in the facility and of related charges for these services, including any charges for services not covered under Medicare or Medicaid, or not covered by the facility's basic per diem rate.

(3) Rights of Incompetent Residents.—Provides for an individual in a SNF or ICF unable (as determined by State law) to exercise his or her rights, the rights (as specified in regulation by the Secretary) that may be exercised by another person on behalf of the resident (as permitted under State law).

(4) Use of Psychotropic Drugs.—No provision.

(c) Transfer and Discharge Rights.—

(1) In General.—Provides that an individual in a SNF or ICF can be transferred or discharged only for medical reasons, or for his welfare and that of other patients, or for nonpayment of his stay (except as prohibited by Medicare or Medicaid), and must be given reasonable advance notice to ensure orderly transfer or discharge. Requires the SNF and ICF to document in a resident's records the circumstances of a discharge or transfer.

(2) Pre-Transfer and Pre-Discharge Notice.—(A) Requires a SNF and ICF to notify a resident, as evidenced by a signed acknowledgement, of the resident's transfer or discharge. (B) Requires that the notice be provided at least 30 days in advance of the resident's transfer or discharge, except where the resident's health improves sufficiently to allow a more immediate transfer or discharge; a more immediate transfer or discharge is necessitated by the resident's urgent medical needs, as explicitly recorded by the attending physician in the resident's record. (C) Similar provision, but without deadline, and with specification that notice include right to appeal the transfer to the State survey and certification agency.

(3) Orientation.—Similar provision, except applies to SNFs and ICFs and also specifies that orientation "provide for" rather than "ensure" safe and orderly transfer or discharge.

(4) Notice on Bed-Hold Policy and Readmission.—

(A) Requires SNFs and ICFs to provide written information to each individual entitled to Medicaid benefits concerning provisions

of the State's plan regarding bed holds, before discharging the resident for hospitalization or therapeutic leave.

(B) Requires SNFs and ICFs, at the time of discharge of a resident to a hospital or for therapeutic leave, to provide written notice to the resident of the duration of any bed hold under the State's Medicaid plan.

(C) No provision.

(D) Requires that State Medicaid plans provide payment for at least three bed hold days for persons furnished SNF or ICF services under the plan.

(d) Access and Visitation Rights.—Requires SNFs and ICFs to: (1) similar, except specifies that "any" officially designated representative have access; (2) similar, except only specifies access of relatives who are visiting with the consent of the individual; (3) permit access by other individuals designated in writing by the resident; (4) similar, except does not specify "other" services and right to deny access; (5) similar provision, with examination of resident's medical, nursing, and social records.

(e) Equal Access to Quality Care.—

(1) General Application.—Requires SNFs and ICFs to establish and maintain identical policies and practices regarding transfers, discharges, and the provision of those services required under Medicare or Medicaid for all individuals regardless of source of payment.

(2) Admissions.

(A) General.—Prohibits SNFs and ICFs from requiring individuals applying to reside or residing in the institution to waive their rights to benefits under Medicare or Medicaid. Requires the institution to display prominently in the institution and to provide to individuals applying to reside or residing in the institution regarding how to apply for and use benefits under Medicare or Medicaid and how to receive refunds for previous payments covered by such benefits. Also prohibits SNFs and ICFs from requiring any oral or written assurance from any person with respect to an individual who is staying in (or applying for admission) the institution that such person will be financially responsible for any charges for the individual. Further prohibits SNFs and ICFs from requiring (as a condition of admission or continued stay in the facility) any nonrefundable deposit, gift, contribution, or prepayment to be made by or on behalf of an individual.

(B) Construction.—With regard to provision prohibiting the institution from requiring a person to accept financial responsibility for charges of a resident, specifies that this provision does not prohibit an institution from requiring a person who is authorized by law to disburse the income of the resident to enter into an agreement to pay, solely from the items and services for which payment may not be made under Medicare or Medicaid.

Also specifies that where an institution furnishes, at the request of an individual, items or services for which payment may not be made (in whole or in part) under Medicare or Medicaid, the institution may require payment by the individual (or by another on behalf of the individual) of such amounts, if, before accepting an item or service, the individual is informed of the amount for which payment will not be made.

Specifies that the eligibility of an individual for benefits under Medicare or Medicaid will not be affected by any such payment made by the individual (or other person on his or her behalf), and the failure to make such payment shall not constitute grounds for transfer or discharge from the institution.

(f) Protection of Resident Funds.—Requires that SNFs and ICFs establish and maintain a system for protecting the personal funds of residents that meets the following requirements:

(1) The institution furnishes each resident, upon admission, with a written statement that (a) describes all services furnished by the institution that can be charged to the resident's personal funds and the extent to which any such service is included in the institution's basic rate; (b) states there is no obligation for the resident to deposit personal funds with the institution and describes the resident's right to select how such funds are handled; and (c) describes the institution's obligation, once it accepts the written authorization of the resident, to hold, safeguard, and account for the resident's personal funds are detailed immediately below.

(2) Upon the institution's acceptance of the written authorization of the resident, (a) the institution deposits any amount of personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the institution's operating accounts and credits to the account all interest earned; (b) the institution maintains personal funds not in excess of $50 in a non-interest bearing account or petty cash fund; and (c) the institution assures a full and complete accounting of the personal funds so as to ensure that there is no commingling of personal funds held by the institution with the funds of the institution or with the funds of any individual other than another resident.

(3) The institution maintains a written record of all financial transactions involving the personal funds of a resident who entrusts personal funds with the institution and affords the resident (or a legal representative of the resident) reasonable access to such record.

(4) The institution purchases a surety bond to guarantee the security of all personal funds of residents entrusted to the institution.

(5) The institution notifies the resident (or a legal representative of the resident) and the State Medicaid agency when the personal funds of the resident entrusted to the institution reach an amount that threatens the resident's eligibility for SSI or Medicaid.

(6) The institution does not charge to the personal funds of a resident the costs of any item or service for which payment is made under Medicare or Medicaid (as the case may be).

Also requires the Secretary to issue, before the first day of the seventh month to begin after the date of enactment of the bill, regulations required under section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (with regard to costs which may be charged to the personal funds of a resident and costs which are to be included in the reasonable costs of the facility). Provides that in the event the Secretary does not issue these regulations, and notwithstanding any other provision of law, the costs which may not be charged to the personal funds of a resident eligible for benefits under Medicare or Medicaid (and for which pay-

ment shall be made under Medicare or Medicaid, as the case may be) shall include, at a minimum, the costs for routine personal hygiene items and services furnished by the facility.

(g) Right to Examine Results of Survey.—Provides residents of SNFs and ICFs with right to examine, upon reasonable request, the results of the institution's most recent certification survey conducted by the Secretary or a State or local agency and any plan of correction in effect for the institution.

Conference agreement

The conference agreement includes both House provisions with an amendment incorporating Senate provisions:

(1) to protect and promote the right of the resident to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility; the right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Secretary or a State or local agency and any plan of correction in effect; and any other right established by the Secretary;

(2) to inform each resident, orally and in writing, at the time of admission, of the resident's legal rights during the stay at the facility; and

(3) to apply transfer and discharge requirements to all transfers and discharges.

Furthermore, the conference agreement incorporates Senate provisions with regard to protection of residents' funds.

(5) Requirements Relating to Administration and other Matters (Section 9211(c) of Ways and Means; Section 4111(e) of Energy and Commerce; and Section 4051(a)(1) of Senate amendment)

Present law

Under current law, SNFs participating in Medicare and/or Medicaid must meet specified requirements relating to administration, conformance with the Life Safety Code, and other matters under 1861(j) of the Medicare statute. They must also meet certain requirements relating to notification in the case of a change in ownership or control in Section 1124 of the Social Security Act. ICFs under Medicaid are required to have methods of administrative management that will enable them to meet other requirements in regulations. They also must meet certain requirements relating to notification in the case of a change in ownership or control.

House bill

Section 9211(c).—

(a) Administration.—Provides that for purposes of Medicare requirements relating to SNFs, a SNF must be administered in a manner that enables it to attain or maintain the highest possible physical, mental and psychosocial well-being of each resident (consistent with requirements established by the Secretary as required under this bill).

(1) Required Notices.—Requires that if a change occurs in the persons with an ownership or control interest in the SNF (as defined by the disclosure of ownership section of the Social Security Act); in the persons who are officers, directors, agents, or managing

employees (as defined under the section of the Social Security Act on disclosure by institutions of individuals who have been convicted of certain offenses); or the individual who is the administrator or director of nursing of the facility, that the SNF provide notice to the State agency responsible for licensing of the facility. Requires notice at the time of the change, of the change and of the identity of the new person or persons.

(2) Nursing Facility Administrator.—Requires the administrator of a SNF to meet any standards established by the Secretary (as specified below under Federal responsibilities for standards).

(3) Licensing and Life Safety Code.—Requires that a SNF be licensed under applicable State and local law. Requires a SNF to meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes; except that the provisions of such Code will not apply in any State if the Secretary finds that in the State there is in effect a fire and safety code, imposed by State law, which provides protection for residents of and personnel in SNF facilities at least equal to the protections provided under such Code.

(4) Sanitary and Infection Control and Physical Environment.—Requires a SNF to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection. Requires the SNF to be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents, personnel and the general public.

(5) Miscellaneous.—Requires a SNF to operate and provide services in compliance with all applicable Federal, State and local laws and regulations (including the requirements of the Social Security Act relating to disclosure of ownership) and with all accepted professional standards and principles which apply to professionals providing services in such a facility. Requires a SNF to meet such other requirements relating to the health, safety and well-being of residents or relating to the physical facilities in the SNF as the Secretary may find necessary.

Section 4111(e).—

(a) Administration.—Similar provision except applies to nursing facilities under Medicaid.

(1) Required Notices.—Similar provision but also requires notice if a change occurs in the corporation, association, or other company responsible for the management of the facility.

(2) Nursing Facility Administrator.—No provision.

(3) Licensing and Life Safety Code.—Similar provision except applies to nrusing facilities under Medicaid and provides that the Secretary may waive, for such periods as he deems appropriate, specific provisions of the Life Safety Code, which is regidly applied would result in unreasonable hardship upon a facility, but only if such waiver would not adversely affect the health and safety of residents of personnel. Provides for an exception from the provisions of such Code in any State if the Secretary finds that in that State there is in effect a fire and safety code, imposed by State law,

which adequately protects residents of the personnel in nursing facilities.

(4) Sanitary and Infection Control and Physical Environment.—Similar provision except applies to nursing facilities under Medicaid.

(5) Miscellaneous.—Similar provision except applies to nursing facilities under Medicaid and requires that a nursing facility must meet such other requirements relating to the health and safety of residents or relating to the physical facilities in the facility as the Secretary may find necessary, which may include any of the additional conditions prescribed by the Secretary for SNFs under Medicare.

Senate amendment

(a) Administration.—Similar provision except applies to SNFs and ICFs and specifies that resources be used effectively and efficiently to maintain and improve the residents' physical, mental and psychosocial wellbeing.

Also requires a SNF to have policies which are developed with the advice of (and with review of these policies from time to time by) a group of professinal personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides. Also requires the SNF to have a physician, a registered professional nurse, or a medical staff responsible for the execution of these policies.

Further requires a SNF to have in effect (1) a utilization review plan that meets the requirements of Medicare law and (2) an overall plan and budget that meet the requirements of Medicare law.

Requires SNFs to cooperate in an effective program that provides for regular independent medical evaluation and audit of the residents of the institution to the extent required by the programs in which the institution participates (including a medical evaluation of each resident's need for SNF services).

(1) Requires Notices.—No provision.

(2) Nursing Facility Administrator.—No provision.

(3) Licensing and Life Safety Code.—Identical to Energy and Commerce provision except applies to SNFs.

(4) Sanitary and Infection Control and Physical Environment.—No provision.

(5) Miscellaneous.—Similar to Ways and Means provision but without specification of professional standards and principles "which apply to professionals providing services in such a facility."

Also provides that, notwithstanding any other provision of law, all information concerning nursing facilities required to be filed under the bill with the Secretary or a State agency shall be made available to Federal and State employees for purposes consistent with the effective administration of programs under Medicare.

Specifies that nothing in the requirements for SNFs and ICFs shall be construed to require an institution that does not participate in Medicaid to accept payments from Medicaid or to accept for treatment any individual for whom payment may be made under Medicaid.

Conference agreement

The conference agreement includes both House provisions.

(6) Requirements Relating to Preadmission Screening for Mentally Ill and Mentally Retarded Individuals (Section 4111(d) of Energy and Commerce; and Sections 4051 (a)(1) of Senate amendment)

Present law

Under the current Medicaid statute, States are required to review patients to determine the appropriateness and quality of care provided. In addition, ICF services may include services in a facility for the mentally retarded if the primary purpose of the institution (or distinct part thereof) is to provide services for the mentally retarded, and if such persons receive active treatment. Furthermore, Medicaid coverage of inpatient psychiatric care is limited to persons 21 years of age of younger or 65 years of age or older. There are no statutory requirements for preadmission screening to determine whether a SNF or ICF is the appropriate level of care required by a mentally retarded or mentally ill person.

House bill

Section 4111(d).—Prohibits a nursing facility from admitting, on or after Jan. 1, 1989, any new resident who (1) is mentally ill (as defined under this bill) unless the State mental health authority has determined prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires active treatment for mental illness, or (2) is mentally retarded (as defined in this bill) unless the State mental retardation or developmental disability authority has determined prior to admission that, because of the physical and mental condition of the individual, the individual requries the level of services provided by a nursing facility and, if the individual requires such level of services, whether the individual requires active treatment for mental retardation. Requires the facility to make a copy of any such determination part of the resident's clinical records.

Senate amendment

Similar provision to Energy and Commerce, except specifies that the basis for the State mental health authority's determination is an independent physical and mental evaluation.

Conference agreement

The conference agreement includes the House provision. As noted above, these provisions were included under requirements that facilities participating in Medicaid must meet for resident assessments.

(7) State Requirements Relating to Nursing Facility Requirements (Section 9211(c) of Ways and Means; Section 4111(f) of Energy and Commerce; and Sections 4051(a)(1), (6), and (7) of Senate amendment)

Present law

Under current Medicare law, the Secretary contracts with the States to utilize the services of the State health agency or other appropriate State agency to determine compliance with Medicare's conditions of participation for SNFs. However, there are no requirements that States establish and approve nurse aide training programs for individuals employed as nurse aides in SNFs. States are not required to establish registries to track or record the qualifications of nurse aides. States are also not required to have in place a system for appealing involuntary transfers or discharges from SNFs.

Under current Medicaid law, the State Medicaid agency is required to contract with the State survey agency used by Medicare (if that agency is the agency responsible for licensing health facilities). There are no requirements that States establish and approve nurse aide training programs for individuals employed as nurse aides in SNFs or ICFs. States are not required to establish registries or record the qualifications of nurse aides. States are also not required to have a system for appealing involuntary transfers or discharges from ICFs or SNFs participating in Medicaid. Medicaid law requires States to have a program for the licensing of administrators of nursing homes. The States are not currently required under their Medicaid plans to develop a written notice of rights, or to have in effect a preadmission screening program for making determinations for mentally ill and mentally retarded individuals.

House bill

Section 9211(c).—

(a) In General.—Adds a new section to the SNF survey and certification provisions of the Medicare statute prohibiting the Secretary from entering into an agreement with a State with respect to determining whether the institution is a SNF unless the State meets the following requirements.

(b) Specification of Nurse Aide Training.—Requires the State by Sept. 1, 1988 to specify those training and testing programs, and those testing programs, that it recognizes and approves for purposes of the nurse aide requirements of this bill and that meet the minimum requirements established by the Secretary for standards for nurse aide training. Prohibits the State from approving a program (1) offered by or in a SNF which has been determined to be out of compliance with the requirements for SNFs (related to provision of services, patients' rights and administration) within the previous two years, or (2) offered by a SNF unless the State makes the determination, upon an individual's completion of the program, that the individual is competent to provide nursing and nursing-related services in SNFs. Provides that the failure of the Secretary to establish standards for nurse aide training programs does not relieve the State of the responsibility to specify approved programs.

(c) Nurse Aide Registry.—Requires the State to maintain a registry of all individuals who have successfully completed a nurse aide training and testing program, or a testing program. Requires the registry to provide (in accordance with regulations of the Secretary) for the inclusion of specific findings of resident neglect or

abuse involving individuals listed in the registry, notice to the individual of the proposed inclusion of such finding with respect to the individual, and for the inclusion of any brief statement of individuals disputing the findings. Requires that in the case of inquiries to the registry concerning a listed individual, that any information disclosed concerning a finding also include disclosure of any such statement in the registry relating to the finding or a clear and accurate summary of the statement. Provides that the failure of the Secretary to establish standards for nurse aide registries does not relieve the State of its responsibility to establish and maintain a registry.

(d) Appeals Process for Involuntary Transfers.—Requires the State to provide a fair mechanism (meeting the guidelines established under this bill) for hearing appeals on involuntary transfers of residents for transfers from SNFs on or after Oct. 1, 1989. Provides that the failure of the Secretary to establish standards for appealing involuntary transfers does not relieve the State of its responsibility for establishing a fair mechanism.

(e) Standards for Facility Administrators.—Requires that by July 1, 1989, the State must have implemented and enforced the nursing facility administrator standards developed under this bill respecting the qualification of SNF administrators.

(f) Notice of Medicaid Rights.—No provision.

(g) State Requirements for Preadmission Screening.—No provision.

(h) State Requirements for Annual Resident Review.—No provision.

(i) Response to Preadmission Screening and Resident Review.—No provision.

(j) Denial of Payment where Failure to Conduct Preadmission Screening.—No provision.

(k) Permitting Alternative Disposition Plans.—No provision.

(l) Appeals Procedures.—No provision.

(m) Definitions.—No provision.

Section 4111(C).—

(a) In General.—Requires States under their Medicaid programs to carry out the following responsibilities in connection with the implementation of the above requirements:

(b) Specification of Nurse Aide Training Programs.—Requires each State, as a condition of approval of its plan under Medicaid, to specify not later than Jan. 1, 1989, those nurse aide training programs that the State recognizes and approves for purposes of the nurse aide training requirements of this bill and that meet the minimum standards established by the Secretary. Provides that the failure of the Secretary to establish such standards does not relieve any State of its responsibility to specify approved programs. Prohibits the State from approving a program (1) offered by or in a nursing facility which has been determined to be out of compliance with the nursing facility requirements within the previous two years, or (2) offered by a nursing facility unless the State makes the determination, upon an individual's completion of the program, that the individual is competent to provide nursing and nursing-related services in nursing facilities. Prohibits the State from delegating this responsibility to the facility.

(c) Nurse Aide Registry.—Requires each State, as a condition of approval of its plan under Medicaid, to establish by not later than Jan. 1, 1989, and maintain a registry of all individuals who have satisfactorily completed an approved nurse aide training program. Requires the registry to meet minimum requirements established by the Secretary under this bill, but failure of the Secretary to issue final regulations does not relieve the State from its responsibility to establish and maintain a registry.

(d) Appeals Process for Involuntary Transfers.—Requires each State, as a condition of approval of its plan under Medicaid, and effective for transfers from nursing facilities on or after Oct. 1, 1989, to provide for a fair mechanism for hearing appeals on involuntary transfers of residents. Requires this mechanism to meet any guidelines established by the Secretary under the requirements of this bill, but the failure of the Secretary to establish such guidelines does not relieve the State of its responsibility for such a fair appeals mechanism.

(e) Standards for Facility Administrators.—No provision.

(f) Notice of Medicaid Appeal Rights.—Requires each State as of April 1, 1988, as a condition of approval of its plan under Medicaid, to develop (and periodically update) a written notice of the rights and obligations of residents of nursing facilities (and spouses of such residents) under Medicaid. Requires this notice to include a description of the provisions of Medicaid law relating to protection of income and resources of community spouses.

(g) State Requirements for Preadmission Screening.—Requires each State, as a condition of approval of its plan under Medicaid, effective Jan. 1, 1989, to have in effect a preadmission screening program, for making determinations (using criteria developed under this bill)—for mentally ill and mentally retarded individuals who are admitted to nursing facilities on or after Jan. 1, 1989.

Provides that the failure of the Secretary to develop minimum criteria (as provided for under the requirements of this bill) does not relieve any State of its responsibility to have a preadmission screening program or to perform resident reviews (as described below.)

(h) State Requirements for Annual Resident Review.—

(1) Mentally Ill Residents.—Requires as a condition of approval of a State plan under Medicaid, as of April 1, 1990, for each mentally ill resident in a nursing facility, that the State mental health authority review and determine (using criteria developed under this bill) whether or not the resident, because of the resident's physical and mental condition, requires the level of services provided by a nursing facility or requires the level of services of an inpatient psychiatric hospital for individuals under age 21 (as described in the Medicaid statute) or of an institution for mental diseases providing medical assistance to individuals 65 or older, and whether or not the resident requires active treatment for mental illness.

(2) Mentally Retarded Residents.—Requires as a condition or approval of a State plan under Medicaid, as of April 1, 1990, for each mentally retarded resident in a nursing facility, that the State mental retardation or developmental disability authority review and determine (using criteria developed under this bill) whether or not the resident, because of the resident's physical and mental con-

dition, requires the level of services provided by a nursing facility or requires the level of services of an intermediate care facility (as described in the Medicaid statute), and whether or not the resident requires active treatment for mental retardation.

(3) Frequency of Reviews.—Requires that the reviews and determinations for mentally ill and mentally retarded residents be conducted for each such resident not less than once per year. Provides that for residents subject to preadmission review, the review and determinaton may be done after the resident has been in the facility for 1 year. Requires that the reviews and determinations for mentally ill and mentally retarded residents be done no later than April 1, 1990.

(i) Response to Preadmission Screening and Resident Review.—Requires as a condition of approval of a State plan, as of April 1, 1990, that the State meet the following requirements:

(1) Requires that for a resident who is determined not to require the level of services provided by a nursing facility, but to require active treatment for mental illness or mental retardation, and who has continuously resided in a nursing facility for at least 30 months before the date of the determination, the State must (in consultation with the resident's family or legal representative and care-givers) inform the resident of the institutional and noninstitutional alternatives covered under the State plan, offer the resident the choice of remaining in the facility or of receiving covered services in an alternative appropriate institutional or noninstitutional setting, clarify the effect on eligibility for services under Medical if the resident chooses to leave the facility (including its effect on readmission to the facility), and regardless of the resident's choice, provide for (or arrange for the provision of) such treatment for the mental illness or mental retardation. Prohibits denial of Medicaid payment to a State for nursing facility services for a resident described under this section because the resident does not require the level of services provided by a nursing facility, if the resident chooses to remain in the facility.

(2) Requires that for residents who are determined not to require the level of services provided by a nursing facility, but to require active treatment for mental illness or mental retardation, and who have not continuously resided in a nursing facility for at least 30 months before the date of the determinaton, the State must (in consultation with the resident's family or legal representative and care-givers) arrange for the safe and orderly discharge of the resident from the facility, prepare and orient the resident for such discharge, and provide for (or arrange for the provision of) such active treatment for the mental illness or mental retardation.

(3) Requires that for residents who are determined not to require the level of services provided by a nursing facility and not to require active treatment for mental illness or mental retardation, the State must arrange for the safe and orderly discharge of the resident from the facility and prepare and orient the resident for the discharge.

(j) Denial of Payment where Failure to Conduct Preadmission Screening.—Prohibits Medicaid payment with respect to nursing facility services furnished to an individual for whom a determination is required but for whom a determination is not made.

(k) Permitting Alternative Disposition Plans.—Requires that for mentally retarded or mentally ill residents who are determined not to require the level of services for a nursing facility, but who require active treatment for mental retardation or mental illness, a State and the nursing facility be considered in compliance if, before Oct. 1, 1988, the State and the Secretary have entered into an agreement relating to the disposition of such residents and the State is in compliance with the agreement. The agreement may provide for the disposition of the residents after April 1, 1990.

(l) Appeals Procedures.—Requires each State, as a condition of approval of its plan under Medicaid, effective Jan. 1, 1989, to have in effect an appeals process for individuals adversely affected by determinations resulting from preadmission screening and annual resident reviews.

(m) Definitions.—Provides definitions for "mentally ill," "mentally retarded," and "active treatment."

Provides that an individual is considered to be "mentally ill" if the individual has a primary or secondary diagnosis of mental disorder (as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition).

Provides that an individual is considered to be "mentally retarded" if the individual is mentally retarded or a person with a related condition, as described in section 1905(d) of Medicaid.

Specifies that the term "active treatment" has the meaning given this term by the Secretary in regulations.

Senate amendment

(a) In General.—No provision.

(b) Specification of Nurse Aide Training Programs.—Requires each State, as a condition of approval of its Medicaid plan, to specify not later than Jan. 1, 1990, those nurse aide training programs that the State recognizes and approves (in consultation with providers, consumers, nurse aides, health care professionals, and other interested groups) and that meet the minimum requirements established by the Secretary.

(c) Nurse Aide Registry.—Requires each State, as a condition of approval of its Medicaid plan, to maintain not later than Jan. 1, 1990, a registry of all individuals who have successfully completed an approved nurse aide training program and records of all test results from these programs.

(d) Appeals Process for Involuntary Transfers.—No provision.

(e) Standards for Facility Administrators.—No provision.

(f) Notice of Medicaid Appeal Rights.—No provision.

(g) State Requirements for Preadmission Screening.—Similar to Energy and Commerce, except amends section 1902 of Medicaid statute to add preadmission screening and resident review to State requirements. Specifies that the program be used for mentally ill and mentally retarded individuals who are being considered for admission to facilities. Does not specify that States are still responsible for a preadmission screening program if the Secretary fails to act.

See also related provision, section 4054 "Federal Review of State Inspection of Care Determinations," of Senate bill, (item #20 in Medicare-Medicaid comparison).

(h) State Requirements for Annual Resident Review.—

(1) Mentally Ill Residents.—Similar provision, except specifies that the State mental health authority shall base its review on an independent physical and mental evaluation. Specifies that the determination include whether the resident, because of the resident's physical or mental condition, or lack of appropriate alternative placement, requires a nursing facility or the level of services provided in another setting, including an inpatient psychiatric hospital or an institution for mental diseases providing medical assistnace to individuals 65 years or older or a program under an approved Medicaid home and community based waiver.

See also related provision, section 4054 "Federal Review of State Inspection of Care Determinations," of Senate bill (item #20 in Medicare-Medicaid comparison).

(2) Mentally Retarded Residents.—Similar provision, except includes programs under an approved home and community based waiver. Provides that the State mental retardation or developmental disability authority review and determine (using criteria developed under this bill) whether or not the resident, because of the resident's physical or mental condition (or the lack of appropriate alternative placement), requires the level of services provided by a nursing facility or requires the level of services of an intermediate care facility (as described in the Medicaid statute), and whether or not the resident requires active treatment for mental retardation.

See also related provision, section 4054 "Federal Review of State Inspection of Care Determinations," of Senate bill (item #20 in Medicare-Medicaid comparison).

(3) Frequency of Reviews.—Identical provision.

(i) Response to Preadmission Screening and Resident Review.—Identical provision.

(j) Denial of Payment where Failure to Conduct Preadmission Screening.—Identical provision.

(k) Permitting Alternative Disposition Plans.—Identical provision.

(l) Appeals Procedures.—Identical provision.

(m) Definitions.—Similar provision of Energy and Commerce, except also provides that the term "nursing facility" means a skilled nursing facility, or intermediate care facility (other than an intermediate care facility for the mentally retarded). Specifies, in addition, that "mentally ill" does not include any organic disease of the brain or dementia (including Alzheimer's disease and related disorders). Specifies that an individual is "mentally retarded" if the individual requires services of the type described in section 1905(d) of Medicaid.

Conference agreement

The conference agreement includes both House provisions with amendments to the Medicaid program to:

(1) specify that an individual is considered to be "mentally ill" if the individual has a primary or secondary diagnosis of mental disorder and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder), and

(2) provide that active treatment does not include services which the facility is otherwise required to provide or arrange for its residents under the requirements of the amended law.

The conference agreement incorporates the Senate requirement that the annual review of mentally ill residents be based on an independent physical and mental evaluation.

(8) Federal Responsibilities for Standards (Section 9211(d) of Ways and Means; Section 4111(g) and 4112 of Energy and Commerce; and Sections 4051(a)(1), (4), (6), and (8) of Senate amendment)

Present law

Under current law, the Secretary has general oversight responsibilities for the assurance that Medicare and Medicaid beneficiaries receive appropriate and adequate care and have their safety, welfare and rights protected. The Secretary is required to consult with State agencies and other organizations to develop conditions of participation for providers of services, including SNFs. The Secretary is also required to promote the effective and efficient use of public money. The Secretary is not required to establish nurse aide training programs for nurse aides employed by SNFs in the Medicare and Medicaid programs. Currently, there are no Federally established appeals rights for involuntary transfers or discharges from SNFs.

Current law provides the Secretary with authority to prescribe appropriate standards for the provision of care in ICFs that participate in Medicaid. However, there are no statutory requirements that the Secretary establish standards for nurse aide training programs of nurse aide registries. There are also no statutory requirements that the Secretary establish appeals rights for involuntary transfers, instruments for resident assessments or criteria for preadmission and resident review.

House bill

Section 9211(g).—

(a) General Responsibilities of the Secretary for Standards.— Amends the Medicare statute relating to SNF requirements to provide for the following Federal responsibilities for standards. Specifies that it is the duty of the Secretary to assure that requirements which govern the provision of care in SNFs under Medicare, and the enforcement of such requirements, are adequate to protect the health, safety, welfare and rights of residents and to promote the effective and efficient use of public moneys.

*(b) Nurse Aide Training Programs.—*Requires the Secretary by March 1, 1988, to establish minimum standards for nurse aide training and testing programs, and testing programs, and minimum standards for the mechanism by which a State approves such programs. Requires that these standards specify the minimum amount of time required for the initial and ongoing training and retraining, including not less than 100 hours with respect to initial training; the areas to be included in a training and testing program, including at least basic nursing skills, personal care skills, cognitive, behavioral and social care, basic restorative services and residents' rights; and the minimum qualifications for instructors in

the programs. Requires that the standards for testing programs specify the areas to be included in the testing programs, including at least basic nursing and personal care skills, cognitive behavior and social care, basic restorative services and resident rights.

Requires that the standards relating to State approval of nurse aide programs specify the frequency with which training and testing programs are to be reviewed by the State and the methodology (including performance-based evaluations as well as analysis of written submissions) by which a State makes determinations whether a program meets the minimum standards.

(c) Federal Guidelines for State Appeals Process for Transfers.—Requires by Oct. 1, 1988, that the Secretary establish guidelines for minimum standards which State appeals processes must meet to provide a fair mechanism for hearing appeals on involuntary transfers of residents from SNFs.

(d) Secretarial Standards for Licensing of Administrators.—Requires by March 1, 1988, that the Secretary develop standards to be applied in the assuring of qualifications of administrators of SNF.

(e) Requirements for Administration.—Requires that with respect to a SNF certified for participation in Medicare, that the Secretary establish by Oct. 1, 1988, requirements with respect to its governing body and management, agreements with hospitals regarding transfers of residents to and from the hospitals and other nursing facilities, disaster preparedness, direction of medical care by a physician, laboratory, radiological and pharmaceutical services, resident care, including clinical records and resident and advocate participation.

(f) Specification of Data Set for Resident Assessments and Penalty for Falsification.—Requires that by Jan. 1, 1989, the Secretary specify a minimum data set of core elements and common definitions for use by SNFs in conducting the resident assessments required by this bill and establish guidelines for use of the data set.

(g) Federal Minimum Criteria for Preadmission Screening and Resident Review.—No provision.

(h) Standards for Assessing Quality of Care..—No provision.

Sections 4111(g) and 4112.—

(a) General Responsibilities of the Secretary for Standards.—Similar provision except applies to Federal responsibilities for nursing facilities under Medicaid.

(b) Nurse Aide Training.—Requires the Secretary to establish by July 1, 1988, minimum standards for training programs for nurse aides, including the curriculum, minimum hours of training, qualifications of instructors, and procedures for determining competency. Provides that such standards may allow recognition of programs offered by or in facilities, as well as outside facilities, and recognition of programs in effect on the date of enactment. Requires the standards to permit a State to find that an individual who has completed (before Jan. 1, 1989) a nurse aide training program to be considered as having completed a program approved under this bill if the State determines that, at the time the program was offered, the program met the requirements for approval under this bill.

Also requires the Secretary to establish by July 1, 1988 minimum standards for the establishment and maintenance of nurse aide registries.

Requires the standards for the registries to provide for the inclusion of documented findings of resident neglect or abuse involving individuals listed in the registry.

(c) Federal Guidelines for State Appeals Process for Transfers.—Similar provision except applies for nursing facilities under Medicaid.

(d) Secretarial Standards for Licensing of Administrators.—No provision (but see below for provision repealing existing requirements for State programs for licensing of administrators of nursing homes).

(e) Requirements for Administration.—Similar provision except provides that the Secretary establish such criteria for assessing a nursing facility's compliance with requirements under Medicaid as specified in this bill. Also does not specify that the Secretary establish requirements for: (1) agreements for transfers of residents to and from other nursing facilities. (2) pharmaceutical services, and (3) resident care. Substitutes "legal representatives" for "advocate" participation.

(f) Specification of Data Set for Resident Assessments and Penalty for Falsification.—Amends the Medicaid statute to require by April 1, 1990, that the Secretary designate one or more instruments which a State may specify for use by nursing facilities in complying with the resident assessment requirements of this bill. Requires the instruments to be consistent with a minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary. Requires as a condition of approval of the State plan and effective July 1, 1990, that each State specify the instrument to be used by the facilities. Requires the instrument to be one designated by the Secretary (as provided above) or one which the Secretary has approved as being consistent with the minimums specified by the Secretary.

(g) Federal Minimum Criteria for Preadmission Screening and Resident Review.—Requires the Secretary to develop by Oct. 1, 1988, minimum criteria for States to use in making determinations (relating to preadmission screening and resident assessments) and in permitting individuals adversely affected to appeal such determinations, and to notify the States of such criteria.

(h) Standards for Assessing Quality of Care.—No provision.

Senate amendment

(a) General Responsibilities of the Secretary for Standards.—No provision.

(b) Nurse Aide Training.—Similar to Ways and Means provision, except (1) requires that Secretary establish minimum standards not later than one year after enactment; (2) specifies "competency evaluation" rather than "testing" programs; (3) requires that standards for initial training specify not less than 75 hours; and (4) does not require that standards specify minimum amount of time required for retraining.

(c) Federal Guidelines for State Appeals Process for Transfers.—Requires the Secretary to establish requirements pertaining to

inter- and intra-institution transfers and discharges, including patient rights of notice and appeal.

(d) Secretarial Standards for Licensing of Administrators.—No provision.

(e) Requirements for Administration.—Requires that the Secretary establish for SNFs and ICFs criteria for assessing an institution's compliance with administration requirements pertaining to its governing body; its management (including nursing services); resident and consumer participation; medical direction and physicians' services (including the use of physicians' assistants and nurse practitioners); laboratory, radiological, and pharmaceutical services; resident care (including medical records); agreements regarding transfers of residents to and from hospitals; and levels of professional staffing.

(f) Specification of Data Set for Resident Assessments and Penalty for Falsification.—Requires the Secretary, not later than Jan. 1, 1990, to specify a minimum data set for use by SNFs and ICFs in conducting resident assessments required under the bill and to establish guidelines for utilization of the data set.

(g) Federal Minimum Criteria for Preadmission Screening and Resident Review.—Similar provision except specifies that the Secretary develop separate minimum criteria with respect to individuals who are mentally ill or mentally retarded.

(h) Standards for Assessing Quality of Care.—Requires the Secretary to establish standards for assessing the quality of care provided by institutions in at least the following areas: (1) vision and hearing, (2) activities of daily living, (3) use of physical restraints, (4) accidents, (5) nutrition and fluid intake, (6) cognitive, behavioral, and social functioning, (7) use of urinary catheters, (8) prevention and care of pressure ulcers and (9) use of drugs.

Conference agreement

The conference agreement includes both House provisions with an amendment incorporating Senate provisions requiring:

(1) the Secretary to issue regulations on those items and services furnished in nursing facilities not chargeable to the personal funds of a resident, and

(2) rules that would apply if the Secretary fails to publish these regulations.

Furthermore, the conference agreement includes an amendment to require the Secretary to review, in a sufficient number of cases to allow reasonable inferences, each State's compliance with requirements relating to discharge and placement of mentally ill and mentally retarded residents.

The conference agreement also incorporates the Senate requirement that the Secretary's standards for nurse aide training include a minimum of 75 hours of initial training. The conferees intend that the Secretary, in establishing standards for nurse aide training, consider standards already developed by non-profit organizations.

(9) Cost of Meeting Requirements (Section 9211(e) of Ways and Means; 4111(b) and (c) of Energy and Commerce; and Sections 4051(a)(3) of Senate amendment)

Present law

Under current law, SNFs participating in Medicare are reimbursed on a reasonable cost basis, or if they provide less than 1,500 days of care to Medicare beneficiaries in a calendar year, they may be reimbursed under a prospective payment system.

States are required to reimburse SNFs and ICFs at rates which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities.

In general, the Federal government shares with States the costs of Medicaid covered services by means of a variable matching formula that is based on a State's per capita income. Federal matching for services ranges from 50 percent to 78.5 percent. Medicaid law also specifies special matching rates for program administration.

In general, the Federal matching rate for program administration is 50 percent, with a 75 percent matching rate for administration costs associated with the compensation or training of skilled professional personnel, and staff supporting these

House bill

Section 9211(e).—Amends the section of the Medicare statute relating to definitions of reasonable costs for SNFs to provide that reimbursement of SNFs take into account the costs, and based on patient-days of services furnished, that facilities incur in complying with the requirements of this bill (relating to provision of services, residents' rights and administration) including the costs of nurse aid training and testing and nurse aide testing programs. Amends the section of the Medicare statute relating to prospective payments of certain SNFs for routine costs to provide that in computing the payment rates, that Medicare take into account costs relating to compliance with the nursing facility requirements of this bill and of conducting nurses aide training and testing programs and nurse aid testing programs.

Section 411 (b) and (c).—Requires that State payment rates to nursing facilities take into account the cost of complying with requirements of this bill related to provision of services, residents' rights, and administration. Also requires States to provide for appropriate reductions in payments where nurse staffing requirements have been waived.

Also requires that the cost of training for nurse aides be eligible for Federal matching payments, regardless of whether the training programs are provided in or outside of nursing facilities or of the skill of the personnel involved in such programs. Provides that during FY88 and FY89, the Federal matching rate for nurse aide training would be the State's regular matching rate for services, plus 25 percentage points, up to 90 percent. Provides that thereafter, the matching rate for the costs of nurse aide training is 50 percent.

Authorizes a 75 percent Federal matching rate for costs attributable to preadmission screening and resident review activities of this bill.

Senate amendment

Amends Medicaid, effective for fiscal years beginning on or after Oct. 1, 1989, to specify that a State's plan shall not be considered to have met the requirement for reimbursing SNFs and ICFs (at rates that are reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities) unless the State has, as of April 1, before the fiscal year concerned, submitted to the Secretary an amendment to the plan to provide for an appropriate adjustment in the payment rates for SNFs and ICFs to reflect the costs of complying with any requirement for these facilities that takes effect during the fiscal year concerned which was not in effect on Oct. 1, 1987, in Federal or State law or regulation. Requires the Secretary to review, not later than Sept. 30 before the fiscal year concerned, each plan amendment submitted for these purposes. Specifies that if the Secretary disapproves the amendment, the State shall immediately submit a revised amendment which meets the requirement. Further specifies that the absence of approval of a plan amendment does not relieve the State or facility of any obligation or requirement under Medicaid.

Conference agreement

The conference agreement includes both House provisions.

(10) Required Report to Congress (Section 9211(f) of Ways and Means; section 4112(a)(3) of Energy and Commerce)

Present law

There is no requirement under current Medicare law that resident assessments be used in determining care requirements for Medicare residents of SNFs. There is also no requirement that a resident assessment be linked or coordinated with a plan of care for the resident.

There is also no statutory requirement for assessments of residents of Medicaid SNFs and ICFs. Regulations provide for a regular medical evaluation and audit for Medicaid SNF residents, and a health care plan for ICF residents.

House bill

Section 9211(f).—Requires the Secretary to evaluate, and report to Congress not later than Jan. 1, 1992, on the implementation of the resident assessment process for residents of SNFs (as created under this bill).

Section 4112(a)(3).—Similar provision except applies to resident assessment process for residents of nursing facilities (as created under this bill).

Senate amendment

No provision.

Conference agreement

The conference agreement includes both House provisions.

(11) Technical Conforming Provisions (Section 9211(g) of Ways and Means; Section 4111(d)–(i) of Energy and Commerce.

House bill

Section 9211(g).—Makes technical conforming changes in certain provisions of the Medicare statute.

Section 4111(d)–(i).—Makes technical changes in the definition of nursing facility in the Medicaid statute. Provides that nursing facility services (as opposed to skilled nursing facility services) are mandatory for adults; eliminates the payment differential between ICFs and SNFs; provides for clarifying terminology; repeals the existing requirements for State programs for licensing of administrators of nursing homes; and makes other technical changes.

Senate amendment

No provision.

Conference agreement

The conference agreement includes both House provisions.

(12) Incorporating Requirements for Nursing Facilities into State Plan (Section 4111(b) of Energy and Commerce; and Section 4051(f) of Senate amendment)

Present law

Section 1902(a) of the Medicaid Statute provides for specific requirements that State Medicaid plans must meet if they are to be approved by the Secretary. If the Secretary finds that a plan is not amended to reflect changes in the requirements, Federal payments may be terminated after reasonable notice and hearing.

House bill

(a) General Application.—Amends the provision of the Medicaid statute relating to payments for nursing facilities under State plans to require State plans to provide (1) that nursing facilities satisfy all requirements specified above; (2) specify the items and services included in nursing facility services; (3) for procedures for making available to the public data and methodology used in establishing payment rates for nursing facilities; and (4) for compliance with various requirements of the bill related to State responsibilities, resident assessment, survey and certification, etc.

(b) State Plan Amendment Required.—Provides that as of April 1, 1989, a State plan under Medicaid will not have met the revised requirements for participation of the law, unless by that date the State has submitted to the Secretary a plan amendment to provide for an appropriate adjustment in payment amounts for nursing facility services furnished on or after Oct. 1, 1989. Requires the Secretary to review and approve or disapprove the amendment by Sept. 30, 1989. If a State's plan amendment is disapproved, requires the State to immediately submit a revised amendment. Provides that the absence of approval of a plan amendment would not relieve the State or any nursing facility of any obligation or requirement under Medicaid as revised by this bill.

Senate amendment

(a) General Application.—No provision.

(b) State Plan Amendment Required.—Requires the Secretary, in consultation (as appropriate) with State agencies administering or responsible for the administration of Medicaid, to compile, a list of the scope and extent of SNF and ICF services that are covered under the State's Medicaid plan and a list of the scope and extent of extended care services and post-hospital extended care services for which payment is made under Medicare. Requires the Secretary, acting through the State agency, to make the first of these lists available to individuals entitled to Medicaid and to providers of the services to which the list applies. Further requires the Secretary to make the second list available to individuals receiving benefits under Part A of Medicare and to providers of the services to which this list applies. Requires the Secretary to provide for the updating of each list to reflect any changes in the services to which the list applies.

Conference agreement

The conference agreement includes the House provision.

(13) Technical Assistance with Developing Case Mix Reimbursement Methodology (Section 4111(j) of Energy and Commerce)

Present law

Current Medicaid law requires State Medicaid plans to provide payment for SNF and ICF services through reasonable and adequate rates determined by State Medicaid agencies. States may use a variety of reimbursement methodologies to pay for nursing home care, including case-mix reimbursement systems.

House bill

Requires the Secretary upon the request by a State to furnish technical assistance with respect to the development and implementation of reimbursement methods for nursing facilities that take into account the case mix of residents in the different facilities.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision.

(14) Report on Staffing Requirements (Section 4111(k) of Energy and Commerce)

Present law

There is no provision in current law.

House bill

Requires the Secretary to report to Congress, not later than Jan. 1, 1993, on the progress made in implementing the nursing facility staffing requirements as amended by this bill, including the number and types of waivers approved and the number of States which have received a delay of an effective date.

Senate amendment

No provision.

Conference agreement

The conference agreement includes the House provision.

(15) Survey and Certification Process (Section 9212 of Ways and Means; Section 4113 of Energy and Commerce; and Section 4051(c) of Senate amendment)

Present law

(a) State Requirement for Survey and Certification Process.—Section 1864 of Medicare law requires the Secretary to enter into agreements with States to survey nursing homes and certify their compliance or noncompliance with Medicare participation requirements. SNFs are surveyed annually by the State agency to determine compliance with Medicare's conditions of participation. In addition, the Secretary has the authority to issue instructions regarding the survey protocol. The Federal government pays for the survey training on a reasonable cost basis, which is included in the survey budget. The funds for the surveys come out of the Medicare Hospital Insurance Trust Fund.

Section 1902(a)(33)(B) of Medicaid law requires the State Medicaid agency to contract with the State survey agency used by Medicare (if that agency is responsible for licensing health facilities) to determine whether facilities meet the requirements for participation in the Medicaid program.

(b) State and Federal Responsibility.—Under Medicaid law, the State survey agency may certify a facility that fully meets requirements and standards for up to 12 months.

The Medicaid program currently authorizes a 75 percent Federal matching rate to the States for costs attributable to compensation or training of skilled professional medical personnel and staff supporting such personnel. A portion of Medicaid nursing home survey costs fall into this category. Other survey-related expenditures under Medicaid are reimbursed at the 50 percent Federal matching rate for general administrative costs.

(c) Standard Surveys.—The Secretary is authorized to conduct onsite surveys of a sample of facilities to evaluate whether the survey agency has correctly determined compliance of the facility with program requirements. These reviews are referred to as validation surveys in the case of Medicare participating facilities, and lookbehind surveys in the case of Medicaid facilities. If the Secretary finds that such a facility fails to meet program requirements and standards, it is authorized to terminate the facility's participation until the reason for the termination has been removed and there is a reasonable assurance that it will not occur.

(d) Extended and Followup Surveys.—There are no current requirements for extended and followup surveys under the Medicare or Medicaid statutes.

(e) Survey Protocol Consistency and Prohibition of Conflicts of Interest.—No provision.

(f) Survey Teams.—No provision.

(g) Validation Surveys.—No provision.

(h) Investigation of Complaints and Monitoring of Compliance.—No provision.

(i) Disclosure of Results of Inspections and Activities and Posting of Survey Results.—No provision.

(j) Special Federal Matching Payments for State Survey and Certification Requirements.—Medicare pays for survey and certification costs out of the Hospital Insurance Trust Fund.

The Medicaid program currently authorizes a 75 percent Federal matching rate to the States for costs attributable to compensation or training of skilled professional medical personnel and staff supporting such personnel. A portion of Medicaid nursing home survey costs fall into this category. Other survey-related expenditures under Medicaid are reimbursed at the 50 percent Federal matching rate for general administrative costs.

House bill

Section 9212.—

(a) State Requirement for Survey and Certification Process.—Amends the Medicare statute (relating to the use of State agencies to determine compliance by providers with the Medicare conditions of participation) to require that in respect to extended care services furnished on or after July 1, 1989, the State must have in effect a survey and certification process for SNFs in the State which meets the requirements specified below.

(b) State and Federal Responsibility.—Requires that each State be responsible for certifying, in accordance with surveys (conducted as described below), the compliance of SNFs (other than facilities of the State) with the requirements of this bill relating to provision of services, residents' rights and administration. Requires the Secretary to be responsible for certifying, in accordance with the surveys, compliance of State-owned SNFs. Requires each State to conduct periodic educational programs for the staff and residents (and their representatives) of SNFs in order to present current regulations, procedures and policies under this section.

(c) Standard Surveys.—Requires each SNF to be subject to a standard survey conducted without prior notice. Provides for civil penalties not to exceed $2000 in the case of an individual who notifies (or causes to be notified) a SNF of the time and date on which such a survey is scheduled. Requires the Secretary to provide for imposition of the civil money penalties in a manner similar to that under current Social Security law. Requires the Secretary to review each State's procedures for the scheduling and conduct of annual standard surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey.

(1) Contents of Standard Survey.—Requires each standard survey to include an audit of a sample of the residents' assessments (as required above under this bill) to determine their accuracy, a survey of the quality of care furnished as measured by indicators of medical, nursing and rehabilitative care, using interviews and observations of a case-mix stratified sample of residents, and a review of the facility's compliance with certain requirements of this bill relating to provision of service, resident's rights and administration).

(2) Frequency of Standard Surveys.—Requires each SNF to be subject to a standard survey not later than 15 months after the

date of the previous standard survey. Requires that the Statewide average interval between surveys of SNFs not exceed 12 months. Provides that a standard survey may be done within 2 months of any change in ownership, administration or management, in order to determine whether the change has resulted in any decline in the quality of care.

(d) Extended and Followup Surveys.—Requires that a SNF be subject to an extended survey if a survey team determines that, because of the poor quality of care found during a standard survey, it would recommend termination of participation of the SNF from Medicare or the appointment of temporary management. Requires the survey team, in such an extended survey, to review and identify the policies and procedures which produced the poor quality of care and to determine whether the SNF has complied with all of the requirements of this bill relating to provision or services, residents' rights and administration. Requires the review to include an expansion of the size of the sample of residents' assessments reviewed and a review of the staffing, in-service training and, if appropriate, contracts with consultants. Provides for any other facility to be subject to such an extended survey or a partial extended survey at the Secretary's or State's discretion.

(e) Survey Protocol, Consistency and Prohibition of Conflicts of Interest.—Requires that standard and extended surveys be based upon a protocol which the Secretary has developed, tested and validated not later than Jan. 1, 1989, and by individuals of a survey team who meet such minimum qualifications as the Secretary establishes not later than Jan. 1, 1989. Provides that the failure of the Secretary to develop, test or validate such protocols or to establish such minimum qualifications does not relieve any State of its responsibility (or the Secretary of his responsibility) to conduct surveys. Requires each State and the Secretary to implement programs to measure and reduce inconsistency in the application of survey results among surveyors. Prohibits a State from using as a surveyor an individual who is serving (or who has served within the previous 2 years) as a consultant to any SNF respecting compliance.

(f) Survey Teams.—Requires surveys to be conducted by a multidisciplinary team of professionals (including a registered nurse and others selected in accordance with regulations of the Secretary). Requires that each State maintain and utilize a specialized team for identifying, surveying, gathering and preserving evidence, and carrying out appropriate enforcement actions against chronically substandard SNFs. Requires that this team include (or have prompt access to) an attorney, auditor, and appropriate health care professionals. Requires each State to provide each member of a survey team with comprehensive preservice training, and in addition to a minimum of 40 hours of continuing education with respect to the conduct of such surveys annually (as approved by the Secretary). Prohibits an individual from serving as a member of a survey team unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary.

(g) Validation Surveys.—Requires the Secretary to conduct sample onsite surveys of SNFs in each State, within 2 months of

the State surveys, in a sufficient number to allow inferences about the adequacies of each State's surveys. Requires that in conducting these surveys, the Secretary use the same protocols as are required for the States. If the State has determined that a SNF meets the requirements of this legislation but the Secretary determines otherwise, the Secretary's determination is binding and supersedes that of the State survey. Provides that if the Secretary finds that a State's survey and certification performance is not adquate or that a State has failed to perform surveys as required, the Secretary may provide for an appropriate remedy, which may include the training of the survey team or the designation of another State to perform survey and certification activities.

Provides that if the Secretary has reason to question the compliance of a SNF with any of the specified requirements of this bill, the Secretary may conduct a survey of the facility and, on that basis, make independent and binding determinations about the extent to which the SNF meets the requirements.

(h) Investigation of Complaints and Monitoring of Compliance.—Requires each State to maintain procedures and adequate staff to investigate complaints of SNF violations of requirements, and monitor on-site, on a regular basis, (daily or more or less frequently) a SNF's compliance with the requirements of this legislation if: (1) the facility has been found to be out of compliance and is in the process of correcting deficiencies to achieve compliance; (2) the facility was previously found not to be in compliance, has corrected deficiencies to achieve compliance, and verification of continued compliance is indicated; or (3) the State has reason to question the compliance of the facility.

(i) Disclosure of Results of Inspections and Activities and Posting of Survey Results.—Requires each State and the Secretary to make available to the public information respecting all surveys and certifications of SNFs, copies of cost reports of such facilities filed under Medicare or Medicaid, copies of statements of ownership as required under the Social Security Act.

Requires that if a State finds that a SNF has provided poor quality of care, it must notify the attending physician of each resident with respect to which such finding is made, and the State board responsible for licensing of the SNF administrator.

Requires that each State provide its State Medicaid fraud and abuse control unit with access to all information of the State agency responsible for surveys and certifications. Amends the Medicare statute relating to State survey and certification to require that the results be posted in a place readily accessible to patients and patients' representatives.

(j) Special Federal Matching Payments for State Survey and Certification Requirements.—No provision.

(k) Revision of Penalty Provisions and Miscellaneous Conforming Amendments.—No provision.

(l) Development of Criteria for the Evaluation of Plans of Correction.—No provision.

Section 4113.—

(a) State Requirement for Survey and Certification Process.—Amends the Medicaid statute relating to survey and certification by adding a new provision as specified below.

(b) State and Federal Responsibility.—Similar provision except (1) applies to Medicaid, (2) specifies that the Secretary be responsible for certifying compliance of "public" facilities with the requirments of the bill, and (3) does not contain requirement for State to conduct periodic educational programs for staff and residents.

(c) Standard Surveys.—Similar provision except applies to nursing facilities under Medicaid and requires that each facility be subject to an annual standard survey.

(1) Contents of Standard Survey.—Similar provision, but requies that the survey include dietary and nutrition services, activities and social participation, and sanitation, infection control, and the physical environment. Also specifies that both audit and survey of quality be based on a case-mix stratified sample of residents. Does not require that standard survey include a review of the facility's compliance with certain requirements relating to provision of service, etc.

(2) Frequency of Standard Surveys.—Similar provision except applies to nursing facilities under Medicaid and includes changes in directors of nursing as a reason for conducting a survey to determine whether the change has resulted in any decline in quality.

(d) Extended and Followup Surveys.—Requires that each nursing facility that is found, under a standard survey, to have provided substandard quality of care be subject to an extended survey to identify policies and procedures that produced such quality and to determine whether the facility has complied with the requirements of this legislation. Requires that the extended survey be conducted immediately after the standard survey (or, if not practical, not later than two weeks after the completion of the standard survey). Provides that this measure does not require an extended or partial survey as a prerequisite to imposing a sanction against a facility on the basis of findings in a standard survey. Provides for any other facility to be subject to an extended survey or a partial extended survey at the Secretary's or State's discretion.

(e) Survey Protocol, Consistency and Prohibition of Conflicts of Interest.—Similar provision, except requires that the Secretary develop, test and validate the survey protocol by April 1, 1990. Requires that the individuals meet minimum qualifications established by the Secretary by April 1, 1990. Prohibits a State from using a surveyor who is serving or who has served as a member of the staff or as a consultant to the facility surveyed.

(f) Survey Teams.—Requires the Secretary to provide for the training of State and Federal surveyors in the use of the assessment instruments (described above in this legislation).

(g) Validation Surveys.—Similar provision except requires the Secretary to conduct onsite surveys of a representative sample of nursing facilities. Provides that if the Secretary finds, on the basis of his surveys, that a State's survey and certification performance is not adequate, the Secretary must provide for a reduction of Federal matching payments for these purposes. Specifies that this reduction would be equal to 33 percent of the ratio of the total number of residents in noncomplying facilities surveyed by the Secretary to the total number of residents in surveyed facilities. Provides that a State may obtain reconsideration and review of the Secretary's findings.

(h) Investigation of Complaints and Monitoring of Compliance.—Similar provision but applies to nursing facilities under Medicaid.

(i) Disclosure of Results of Inspection and Activities and Posting of Survey Results.—Similar provision except applies to nursing facilities under Medicaid. Also requires public disclosure of information supplied under Medicaid State plans about certain subcontractors' ownership and certain business transactions Also, requires each State to notify the State long-term care ombudsman of the State's finding of noncompliance. Specifies that attending physicians and State licensing boards be notified of a finding of "substandard," rather than "poor," quality of care.

(j) Special Federal Matching Payments for State Survey and Certification Requirements.—Provides special Federal matching payment rates for States' survey and certification activities (as found necessary by the Secretary for the proper and efficient administration of the State plan): 90 percent of sums expended in FY1990, 85 percent in FY1991, 80 percent in FY1992, and 75 percent thereafter.

Provides that expenses incurred by the State for medical review by independent professionals of the care provided to residents of nursing facilities who are entitled to Medicaid be matched at the administrative matching rate of 50 percent.

(k) Revision of Penalty Provisions and Miscellaneous Conforming Amendments.—Repeals various requirements relating to surveys, inspections of care, and certification and recertification of need for SNF and ICF care. Specifies, however, that such amendments shall not apply until such date (not earlier than Oct. 1, 1990) when the Secretary determines that the State has specified the resident assessment instrument which should be used by facilities and the State has begun conducting standard and extended surveys.

(l) Development of Criteria for the Evaluation of Plans of Correction.—No provision.

Senate amendment

(a) State Requirement for Survey and Certification.—Amends the Medicare statute (relating to the use of State agencies to determine compliance by providers with Medicare conditions of participation) to require that the Secretary's agreement with the State include SNFs and ICFs among those facilities surveyed by State agencies. Adds additional requirements for the survey and certification process for SNFs and ICFs as described below.

(b) State and Federal Responsibility.—Similar provision except applies to SNFs and ICFs and does not contain requirement for States to conduct periodic educational programs for staff and residents.

(c) Standard Surveys.—Requires that each SNF and ICF be subject to a standard survey of the facility's compliance with applicable requirements specified in law. Specifies that standard surveys be conducted on an unannounced basis.

(1) Contents of Standard Survey.—Requires that a standard survey include audits of a sample of residents' assessments as required above under the bill.

(2) Frequency of Standard Surveys.—Provides that a standard survey may be conducted upon any change of ownership and must

otherwise be conducted not later than 15 months after the date of the previous survey. Also requires that the frequency of standard surveys be based upon the degree to which a facility was found, in the most recently conducted survey, to be in compliance with the requirements of law. Requires that the Statewide average interval between surveys not exceed 12 months.

(d) Extended and Followup Surveys.—Requires that each SNF and ICF, found to have performed poorly in one or more requirements of law, be subject to an extended survey. Provides that any other facility may be subject to an extended survey at the Secretary's or State's discretion.

(e) Survey Protocol, Consistency and Prohibition of Conflicts of Interest.—Requires that all surveys be based upon regulations the substance of which the Secretary has developed, tested, and validated by Jan. 1, 1990. Requires each State to implement programs to measure and reduce inconsistency in the application of survey results among surveyors. Prohibits a State from using as a member of a survey team any individual who is serving (or has served in the previous 2 years) as an employee of or consultant to the particular facility being surveyed. Also requires that the Secretary, together with each State survey agency, develop written procedures for review of survey findings in cases where the provider of services has substantial disagreement with such findings. Requires that such procedures shall include a system for resolving significant differences in professional judgments about the appropriateness and quality of care (but in no event shall delay the timing of any enforcement action).

(f) Survey Teams.—Similar to Ways and Means provision except (1) applies to SNFs and ICFs; (2) specifies "initial" training rather than "preservice" training for members of the team and does not require State to provide training; (3) requires that surveys be conducted with such teams not later than Jan. 1, 1990; (4) specifies "duties" rather than "purpose" of specialized survey team; and (5) prohibits "health care professionals" rather than "individuals" from serving on team unless he or she has completed an approved training and testing program and has experience or education in gerontological nursing or long-term care and in interviewing residents with communicative impairments.

(g) Validation Surveys.—Requires the Secretary to conduct surveys of SNFs and ICFs in each State in a sufficient number to allow inferences about the adequacy of each State's surveys. Requires that these surveys be conducted within one month of the most recently conducted State survey of the facility. Also requires that the number of these surveys amount to no fewer than five percent of the facilities surveyed by the State in a year (or no fewer than five facilities). Provides that if the results of the Secretary's survey differ from the State's, then the Secretary's results will be conclusive for purposes of a determination about compliance.

Also requires the Secretary, no later than one year after the date of enactment, to prescribe by regulation (1) performance and outcome standards to evaluate and assure the effectiveness of State survey activities (including standards to evaluate the general improvement in quality of care in certified facilities, how the findings from such activities compare with the Secretary's review findings,

the appropriateness and effectiveness of State enforcement action, the extent to which repeat deficiencies occur, the extent to which deficiencies are not corrected in a timely manner, and complaint handling activities); and (2) administrative sanctions to be imposed on State survey agencies for poor performance in relation to the proportion of beneficiaries placed at risk by such performance.

See also related provision, section 4054 "Federal Review of State Inspection of Care Determinations," of Senate bill (item #20 in Medicare-Medicaid comparison).

(h) Investigation of Complaints and Monitoring of Compliance.—Requires each State to maintain procedures and adequate staff to investigate complaints of violations by facilities of applicable requirements.

(i) Disclosure of Results of Inspections and Activities and Posting of Survey Results.—Requires that each State and the Secretary make available to the public information with respect to all surveys and certifications of SNFs and ICFs and information with respect to cost reports of such facilities filed under Medicare or Medicaid.

Requires that State survey agencies ensure that survey procedures are coordinated with the activities of State fraud and abuse units, resident protection and advocacy units, and the State Medicaid agency.

Requires that State survey agencies enter into a written agreement with the appropriate State long-term care ombudsman to provide for information exchange, training, case referral, and prompt notification of the ombudsman of any adverse action to be taken by the agency against a SNF or ICF. Requires that the agreement provide for access by the ombudsman to any inspection reports and notices of deficiencies, sanctions, or adverse determinations issued by the agency, and, consistent with Federal and State laws governing confidentiality of information, to investigate reports and findings made on account of complaints of ombudsman.

Amends the Medicare statute relating to State survey and certification to require that the results of surveys of SNFs and ICFs be posted in a place readily accessible to residents and residents' representatives.

Also amends title XI of the Social Security Act, relating to disclosure of validation survey reports and other formal evaluations of providers, to shorten the period of time, from 60 to 30 days, that the provider would have to review the report and make comments on it before the report is made public. However, the Secretary may release the report to a State long-term care ombudsman or a designee before the end of the 30-day period.

(j) Special Federal Matching Payments for State Survey and Certification Requirements.—No provision.

(k) Revision of Penalty Provisions and Miscellaneous Conforming Amendments.—No provision.

(l) Development of Criteria for the Evaluation of Plans of Correction.—Requires the Secretary to develop and implement criteria and procedures for the evaluation of plans of correction submitted by institutions seeking compliance with the standards for SNFs and ICFs. Requires that the criteria and procedures be designed (1) to maximize specifically in the plans, (2) to require on-site evalua-

tion of the implementation of plans dealing with deficiencies relating to patient care, and (3) to emphasize the need for correction to provide for permanent compliance with the standards.

Conference agreement

The conference agreement includes both House provisions with an amendment incorporating Senate provisions to require the Secretary to conduct validation surveys with respect to no fewer than 5 precent of the facilities surveyed by the State in a year but in no case less than 5 facilities in a State.

In addition, the conference agreement includes, with regard to Medicare, a requirement that the Secretary shall provide, when the survey and certification performance is not adequate, for an appropriate remedy, which may include the training of the survey team. For purposes of Medicaid only, the Secretary shall provide for a reduction of the payment otherwise made to the State when the survey and certification performance is not adequate.

Furthermore, the conference agreement requires, with regard to nurse aide registries, that the State provide through the survey and certification agency for a process for the receipt, review, and investigation of allegations of resident neglect and abuse (including misappropriation of personal funds) by a nurse aide. The conferees intend that any nurse aide against whom an allegation of neglect and abuse (or misappropriation of personal funds) is made shall be given an opportunity for a hearing before the State survey and certification agency. No nurse aide's name shall be placed on the registry until the individual has been notified of the right to a hearing, and either a hearing has taken place and the allegations have been substantiated, or the individual has waived, after being given a reasonable opportunity, his/her right to a hearing. Only a survey and certification agency, based on documented findings, shall place the individual's name on the registry. The conferees intend that a facility, resident, ombudsman, or any other individual or organization may contact the survey team, and the survey team shall investigate the allegation.

The conferees also suggest that the Secretary consider, in establishing criteria by which the standard survey will measure quality of care furnished by a facility, such factors as vision and hearing; activities of daily living; use of physical restraints; accidents; nutrition and fluid intake; cognitive, behavioral, and social functioning; use of urinary catheters, prevention and care of pressure ulcers; and use of drugs.

(16) Enforcement Process and Intermediate Sanctions (Section 9213 of Ways and Means; section 4114 of Energy and Commerce; Section 4051(d) of Senate amendment)

Present law

Under the current Medicare and Medicaid statutes, when a finding is made that a nursing home no longer substantially meets the law's requirements and standards of care, and deficiencies do not immediately jeopardize the health and safety of its patients, the Secretary and/or State may, in lieu of termination, refuse to make payments on behalf of individuals later admitted to the facility. However, if it is determined that the deficiencies do immediately

jeopardize the health and safety of the facility's patients, the Secretary or State must terminate the facility's participation in the program. If the decision is made to deny program payment instead of terminating a facility's participation, the facility must achieve substantial compliance with program requirements or be found to have made a good faith effort to correct its deficiencies by the end of the eleventh month following the month when a decision is made to deny payment. Final regulations implementing these provisions became effective August 4, 1986.

Currently, there are no statutory requirements for the coordination of conflicting or overlapping State and Federal remedies. However, under current law Federal remedies do take procedence over State remedies.

House bill

Section 9213.—

(a) General Requirements.—Amends the current Medicare law relating to State enforcement of Medicare conditions of participation to require the State to establish and apply the remedies as specified below to SNFs that fail to meet the requirements of this legislation.

(b) Requirements for State Enforcement Process.—Requires that if a State finds that a SNF no longer meets the requirements of this bill (relating to provision of services, patients' rights and administration) and further finds that the facility's deficiencies immediately jeopardize the health or safety of its residents, the State must take immediate action to remove the jeopardy and correct the deficiencies (including the appointment of temporary management) or terminate immediately the facility's Medicare participation and, in addition, may also provide for one or more of the remedies described below. Provides that if the deficiencies do not immediately jeopardize the health or safety of its residents, the State may terminate the facility's participation or may provide, in addition, for one of the remedies described below. Provides that this provision does not restrict the remedies available to a State to remedy a SNF's deficiencies.

(c) Specific State Remedies.—

(1) Required Remedies.—Requires, with certain exceptions (see alternative remedies under 2B), that each State establish by law (statute or regulation) at least the following remedies: (A) denial of payment under Medicare with respect to any individual admitted to the SNF after the required notices are provided to the public and the SNF; (B) a civil money penalty assessed and collected for each day in which the SNF remains out of compliance; (C) the appointment of temporary management to oversee the operation of the SNF and to assure the health and safety of its residents, where there is a need for temporary management while there is an orderly closure of the SNF, or improvements are made in order to bring it into compliance; and (D) the authority, in the case of an emergency, to close the SNF, to transfer residents in that SNF to other facilities, or both.

(2) Deadline and Guidance.—(A) Requires that as a condition of entering into agreement with Medicare (and with respect to determining on or after Oct. 1, 1989 whether institutions qualify as

SNFs under Medicare) that each State establish the remedies described above by July 1, 1989. Requires by Oct. 1, 1988 that the Secretary provide, through regulations or otherwise, guidance to the States in establishing the remedies. Provides that the failure of the Secretary to provide this guidance does not relieve a State of the responsibility for establishing the remedies. (B) Provides that a State may establish alternative remedies (expect termination of participation) other than those described above, if the State demonstrates to the Secretary's satisfaction that the alternative remedies are as effective in deterring noncompliance as those specified above.

(3) Assuring Compliance.—Provides that if a SNF has not complied with any of the requirements (relating to provision of services, residents' rights and administration) within 6 months after the SNF is found to be out of compliance, the State must deny Medicare payments for all individuals, who are admitted to the SNF after the date on which noncompliance was established.

(4) Funding.—No provision.

(5) Repeated Noncompliance.—No provision.

(6) Incentives for High Quality Care.—No provision.

(d) Secretarial Authority.— Provides that with respect to a State SNF, the Secretary has the authority and duties of a State in respect to imposing sanctions and remedies. Provides that for any other SNF in a State, the Secretary may in specified circumstances, exercise the authority of the State. Provides that in exercising authority to impose civil money penalties, the Secretary must base the amount of the penalty on the severity and frequency of the noncompliance and the size of the SNF and may not impose a penalty that exceeds $10,000 for each day of noncompliance. Provides that the Secretary impose and collect such penalties in the same manner as they are imposed and collected under the relevant provision of the Social Security Act.

In addition, see (f), (g), and (h) below.

(e) Effective Period of Denial of Payment.—Provides that a finding to deny payments would terminate when the State or Secretary (or both) finds that the SNF is in compliance.

(f) Remedies Where State or Secretary Finds Noncompliance and Immediate Jeopardy.—Provides that if either the State or the Secretary finds that a SNF has not met the requirements of this bill (relating to provisions of services, patients' rights, and administration) and finds that the failure immediately jeopardizes the health or safety of its residents, the State must take immediate action to remove the jeopardy and correct the deficiency (including the appointment of temporary management and the denial of payment for new residents until the SNF is in compliance). Provides that if the State determines that if the State determines that it is necessary to terminate immediately the SNF's participation agreement, the State must provide for the safe and orderly transfer of the Medicare residents consistent with the requirements for patients' rights in case of transfer or discharge (as specified in this bill).

(g) Special Rules where the Secretary and State Disagree on Finding of Noncompliance.—(1) Provides that if the Secretary finds a SNF in compliance but a State finds that the SNF is out of compliance, and if the failure does not immediately jeopardize the health

and safety of the residents, then the State's findings control and the remedies imposed by the State apply. (2) Provides that if the Secretary finds a SNF out of compliance but the State has not, and if the failure does not immediately jeopardize the health and safety of the residents, then the Secretary may impose remedies (other than termination of participation).

(h) Special Rules for Enforcement Actions Where the Secretary and the State find Noncompliance But Disagree on Corrective Actions.—

(1) General Rules.—Provides that if both the Secretary and the State find a SNF out of compliance and both find that its participation should be terminated, but neither finds that its deficiency immediately jeopardizes the health and safety of its residents, then the State's determination of corrective actions and timing of these actions takes precedence over determinations by the Secretary so long as such actions do not occur more than 6 months after the date of the finding of noncompliance.

(2) Construction.—Provides that the remedies provided under this section are in addition to those otherwise available under State or Federal law and are not to be construed as limiting those other remedies. Provides that the following remedies may be imposed while a hearing is pending: denial of payment, appointment of temporary management, or closing of the facility.

(i) Sharing of Information.—Provides that notwithstanding any other provision of law, all information concerning SNFs required by this section to be filed with the Secretary or a State agency must be made available to Federal or State employees for purposes consistent with effective administration of Medicare and Medicaid programs.

Section 4114.—

(a) General Requirements.—Provides for revisions of current Medicaid law regarding enforcement of compliance with the requirements for Medicaid participation as specified below.

(b) Requirements for State Enforcement Process.—Similar provision except specifies that findings of deficiency be based on a standard, extended or partial survey, or otherwise, and applies to requirements for nursing facilities under Medicaid. Also specifies that for immediate jeopardy cases, the State must take immediate action to remove the jeopardy and correct deficiencies "through" the appointment of temporary management or terminate the facility. For non-immediate jeopardy cases, the State may terminate "and" may provide for additional remedies. Also provides that if a State finds that a nursing facility meets the requirements but, as of a previous period, failed to meet them, the State may impose a civil money penalty for the days in which the facility was out of compliance.

(c) Specific State Remedies.—

(1) Required Remedies.—Similar provision, except that it applies to nursing facilities under Medicaid. Provides that the remedy of the civil money penalty be assessed and collected with interest. Provides that the funds collected by a State as a result of imposition of such a penalty (or as a result of the imposition by the State of a civil penalty for specified activities relating to resident assessments and survey and certification) be applied to the protection of

the health or property of residents of nursing facilities that the State or the Secretary finds deficient, including payment for the costs of relocation of residents to other facilities, maintenance of operation of a facility pending correction of deficiencies or closure, and reimbursement of residents for personal funds that are lost. Finally, requires that in the application of the remedy of appointing temporary management, that the management not be terminated until the State has determined that the facility has the management capability to ensure continued compliance.

(2) Deadline and Guidance.—Similar provision except applies as a condition for approval of a State plan for calendar quarters beginning on or after Oct. 1, 1989.

(3) Assuring Compliance.—Similar provision except applies to facilities under medicaid and provides for denial of Medicaid payments if the facility fails to comply within 3 months of the determination of noncompliance.

(4) Funding.—Provides that reasonable State costs for exercising the temporary management of emergency closure remedies would be eligible for Federal Medicaid matching funds at the administrative matching rate of 50 percent.

(5) Repeated Noncompliance.—Requires in the case of a facility which, on 3 consecutive standard surveys, that the State deny payments for newly admitted patients and monitor the facility (as specified by this bill under requirements for monitoring of compliance) until it has demonstrated to the satisfaction of the State that it is in compliance and that it will remain in compliance.

(6) Incentives for High Quality Care.—Provides that in addition to the other remedies specified above, a State may establish a program to reward, through public recognition, incentive payments or both, nursing facilities that provide the highest quality care to residents entitled to Medicaid. Provides that State costs for carrying out such a program would be eligible for Federal matching payments at a rate of 50 percent.

(d) Secretarial Authority.—

(1) Similar provision in respect to State nursing facilities, except applies to nursing facilities under Medicaid and does not include the authority to close the facility and/or tranfer residents. Provides that for other nursing facilities in a State, that if the Secretary finds a facility not in compliance and further finds that the facility's deficiencies immediately jeopardize the health or safety of its residents, the Secretary must take immediate action to remove the jeopardy and correct the deficiencies by providing for temporary management or by terminating the facility's participation in Medicaid and may also provide for other remedies described below. Provides that if the deficiencies do not immediately jeopardize the health or safety of its residents, the Secretary may impose any of the remedies described below. Provides that this does not restrict the remedies available to the Secretary to remedy a facility's deficiencies.

In addition, see (f), (g), and (h) below.

Also provides that if the Secretary finds that a nursing facility meets requirements but, as of a previous period, failed to meet the requirements, the Secretary may impose a civil money penalty for the days in which the facility was out of compliance.

(2) Specifies remedies available to the Secretary. Provides that he may take the following actions with respect to a finding that a facility has not met an applicable requirement: (A) the Secretary may deny further payments to the State for medical assistance to all individuals in the facility or to individuals admitted after the effective date of the finding; (B) the Secretary may impose a civil money penalty not to exceed $10,000 for each day of noncompliance and the Secretary must impose and collect such a penalty in the same manner as they are imposed and collected under the relevant Social Security law; (C) in consultation with the State, the Secretary may appoint temporary management to oversee the operation of the facility to assure the health and safety of its residents, where there is a need for temporary management while there is an orderly closure of the facility, or improvements are made in order to bring the facility into compliance. Prohibits termination of the temporary management until the Secretary has determined that the facility has the management capability to ensure continued compliance.

(3) Provides that the Secretary may continue Medicaid matching payments to a State for care provided by a facility not in compliance, for no more than 6 months, if: (A) the State survey agency finds that it is more appropriate to take alternative action to assure compliance than termination of certification; (B) the State has submitted a plan and timetable for corrective action to the Secretary for approval which the Secretary approves; and (C) the State agrees to repay the Federal payments if the corrective action is not taken in accordance with the approved plan and timetable. Requires the Secretary to establish guidelines for approval of corrective actions requested by the States.

(e) Effective Period of Denial of Payment.—Similar provision but applies to nursing facilities under Medicaid.

(f) Remedies Where State or Secretary Finds Noncompliance and Immediate Jeopardy.—Similar provision except applies to requirements for nursing facilities under Medicaid. Requires the State and the Secretary to notify the other of such finding, and the State or the Secretary to take immediate action to remove the jeopardy and correct the deficiencies through appointment of temporary management or termination of participation. Requires that in the case of termination, the State must provide for the safe and orderly transfer of the Medicaid residents.

(g) Special Rules where the Secretary and State Disagree on Finding of Noncompliance.—Similar provision, except applies to facilities under Medicaid. Provides that in the latter case, the Secretary may impose certain remedies and is required (pending any termination by the secretary) to permit Federal matching payments.

(h) Special Rules for Enforcement Actions Where the Secretary and the State find Noncompliance But Disagree on Corrective Actions.—

(1) General Rules.—Similar provision except applies to nursing facilities under Medicaid. Provides that if both the Secretary and the State find a facility out of compliance, that both find that the failure does not immediately jeopardize the health and safety of the residents, but only the Secretary finds that the facility's participation should be terminated, then the Secretary must (pending

any termination by the Secretary) permit continuation of Federal matching payments. Provides that if the State but not the Secretary finds that the facility's participation should be terminated, the State's decision to terminate and the timing of the termination applies. If either the Secretary or the State establish remedies in addition or as an alternative to termination, then such other remedies apply. If both the Secretary and the State establish other remedies than termination, only those of the Secretary apply.

(2) Construction.—Similar provison except specifies that these remedies do not limit other remedies, including any remedy available to an individual under common law.

(i) Sharing of Information.—Similar provision except also applies to investigations by State Medicaid fraud control units.

Senate amendment

(a) General Requirements.—Amends the current Medicare law relating to the Secretary's enforcement of compliance with the requirements for participation in Medicare and Medicaid by SNFs. Amends also the Medicaid law relating to State enforcement of compliance with requirements for ICF participation in Medicaid.

(b) Requirements for State Enforcement Process.—Similar provision except requires that if a State determines that a SNF or ICF (other than an intermediate care facility for the mentally retarded) that is certified for participation under Medicaid no longer meets the applicable requirements and further determines that the facility's deficiencies do not immediately jeopardize the health and safety of its residents, the State may, instead of terminating the facility's participation, impose one or more of the sanctions specified below.

(c) Specific State Remedies.—

(1) Required Remedies.—Requires the State to develop and implement a range of intermediate sanctions to apply to facilities for which the deficiencies have been determined not to immediately jeopardize the health and safety of their patients. Requires these sanctions to include: (A) directed plans of correction; (B) the appointment of receivers (in accord with provisions specified below); and (C) one or more of the following sanctions: civil fines; on-site monitoring by an agency responsible for conducting certification surveys (with the costs of such monitoring to be paid by the facility without reimbursement); withholding or reducing amounts otherwise payable to the facility; and any other sanction designated or approved by the Secretary.

Requires the State to develop and implement specific criteria as to when and how each of these intermediate sanctions is to be applied; the amounts of any fines, and the severity of each of the penalties.

Requires the criteria to be designed to minimize the time between identification of violations and final imposition of the sanctions. Also requires that the criteria provide for the imposition of incrementally more severe penalties for repeated or uncorrected deficiencies. Provides that in accord with such criteria, the State may impose any sanction in lieu of, or in addition to, termination of participation.

Requires that where a State determines that a SNF or an ICF (other than an ICF/MR) that is certified for participation under its plan is chronically failing to meet substantially Medicare or Medicaid requirements, or determines that the facility's deficiencies immediately jeopardize the health and safety of its patients, the State shall give public notice of such determination, and the State may appoint a receiver to (A) oversee the operation of the facility; (B) establish and oversee the implementation of a correction plan to bring the facility into compliance by a date specified in the correction plan, and (C) assure the health and safety of the facility's patients during the facility's receivership period.

Requires that subject to current law relating to Medicaid facilities that are found to be out of compliance, that State Medicaid payment be made with respect to any services furnished by any such facility during any period of receivership ordered by the Secretary or the State.

Requires that public notice be given in any case in which such deficiencies are determined to be rectified.

(2) Deadline and Guidance.—No provision.

(3) Assuring Compliance.—No provision.

(4) Funding.—No provision.

(5) Repeated Noncompliance.—No provision, but see (c)(1) above relating to specific state remedies.

(6) Incentives for High Quality Care.—No provision.

(d) Secretarial Authority.—

(1) Requires the Secretary to develop and implement a range of intermediate sanctions to apply to facilities with deficiencies that have been determined not to immediately jeopardize the health and safety of their patients. Requires that such sanctions include: (A) directed plans of correction; (B) the appointment of receivers (as provided below); and (C) one or more of the following sanctions: civil fines; on-site monitoring by an agency responsible for conducting certification surveys (with the costs of such monitoring to be paid by the facility without reimbursement); withholding or reducing amounts otherwise payable to the facility under Medicare or Medicaid; and any other sanction designated or approved by the Secretary.

Requires the Secretary to implement specific criteria as to when and how each of these intermediate sanctions is to be applied; the amounts of any fines, and the severity of each of the penalties.

Requires the criteria to be designed to minimize the time between identification of violations and final imposition of the sanctions. Also requires that the criteria provide for the imposition of incrementally more severe penalties for repeated or uncorrected deficiencies. Provides that in accord with such criteria, the Secretary may impose any sanction in lieu of, or in addition to, termination of participation.

Requires that in any case where intermediate sanctions imposed by a State pursuant to this bill are in effect with respect to a facility, the Secretary shall review periodically (not less than once every 3 months) the effectiveness of such sanctions in promoting the correction of the deficiencies involved and shall withhold action unless the Secretary determines that such sanctions are ineffective or immediately jeopardize the health and safety of its patients.

(2) Requires that in any case where the Secretary determines that a SNF is chronically failing to meet substantially Medicare requirements or of the provider agreement, or determines that the facility's deficiencies immediately jeopardize the health and safety of its patients, the Secretary shall give public notice of such determination, and in the case of a SNF that is not in a period of State-ordered receivership, the Secretary may appoint a receiver to oversee the operation of the facility, establish and oversee the implementation of a correction plan to bring the facility into compliance with the applicable requirements of the State plan, Medicare, Medicaid and State licensing requirements by a date set forth in the correction plan; and assure the health and safety of the facility's patients during the receivership period.

(3) Requires that Medicare payment be made with respect to any services furnished by any such facility to patients who remain in the facility during any period of receivership ordered by the Secretary or the State.

(4) Provides that a period of State-ordered receivership with respect to a facility is a period during which the State has appointed a receiver to oversee the operation of the facility; the State has in effect a correction plan to bring the facility into compliance with the applicable requirements of the State plan, Medicare, Medicaid and State licensing requirements by a date set forth in the correction plan; and the State has taken measures to assure the health and safety of the facility's patients during the period.

(5) Requires that public notice be given in any case in which such deficiencies are determined to be rectified.

(6) Requires the Secretary to provide States with technical assistance in the development and implementation of sanctions authorized under this bill.

(e) Effective Period of Denial of Payment.—No provision (except that bill provides that such decisions are at the Secretary's discretion).

(f) Remedies Where State or Secretary Finds Noncompliance and Immediate Jeopardy.—No provision.

(g) Special Rules where the Secretary and State Disagree on Finding of Noncompliance.—No provision.

(h) Special Rules for Enforcement Actions Where the Secretary and the State find Noncompliance But Disagree on Corrective Actions.—

(1) General Rules.—No provision.

(2) Construction.—No provision.

(i) Sharing of Information.—No provision in "Enforcement" section of bill, but similar provision above in item #5(a)(5) under "Requirements Relating to Administration and Other Matters."

Conference agreement

The conference agreement includes both House provisions with an amendment incorporating Senate provisions to require both the State and the Secretary to specify criteria as to when and how intermediate sanctions are to be applied, the amount of any fines, and severity of each of the intermediate sanctions. The provisions also require these criteria to be designed so as to minimize the time between the identification of violations and final imposition of the

intermediate sanctions and to provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. The conference agreement also incorporates a Senate provision authorizing a State to provide for other intermediate sanctions, such as directed plans of correction.

(17) Effective Dates (Section 9214(a) of Ways and Means; Section 4116(a) and 4116(b) of Energy and Commerce; Sections 4051(a)(7), (c)(6), and (d)(3) of Senate amendment)

House bill

Section 9214(a).—

Except as otherwise specifically provided, applies to extended care services furnished on or after Jan. 1, 1989.

Sections 4116(a) and 4116(b).—

Except as otherwise specifically provided in section 1921 of the Social Security Act, the amendments made by sections 4111 and 4113 (relating to nursing facility and survey and certification requirements), applies to nursing facility services furnished on or after Oct. 1, 1989, without regard to whether regulations are promulgated, except that the provision relating to requiring State medical assistance plans to specify the services included in nursing facility services (4111(b)) applies to calendar quarters beginning at least 6 months after enactment. Provides that the amendments made by section 4112 and 4114 apply to Medicaid payments for calendar quarters beginning on or after enactment, without regard to whether regulations are promulgated.

Provides that in applying amendments made by section 4114 for services furnished before Oct. 1, 1989, than any reference to a nursing facility is deemed a reference to a SNF or ICF (other than ICFs for the mentally retarded), and with respect to such a SNF or ICF, any reference to requirements is deemed a reference to specified sections of the Social Security Act.

Senate amendment

Except as otherwise specifically provided, effective as of the date of enactment. (The amendments made by section 4051(c) relating to survey and certification are effective Oct. 1, 1988. The amendments made by section 4051(a)(7) relating to preadmission screening and assessment for mentally ill and mentally retarded individuals is effective for services furnished on or after Jan. 1, 1988, except that the provisions as applied to ICFs relating to annual resident reviews apply in the case of facilities with more than 120 beds to services furnished on or after Oct. 1, 1988; in the case of facilities with more than 60 beds but less than 120, to services furnished on or after Oct. 1, 1990; and in the case of facilities with 60 beds or less, to services furnished on or after Oct. 1, 1992. The amendments made by section 4051(d)(3) relating to enforcement are effective Oct. 1, 1990.

Provides that in the case of a State Medicaid plan which the Secretary determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements of certain amendments of this bill, the State plan will not be regarded as failing to comply with these requirements solely on the basis of its failure to meet them before the first day of

first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment.

Conference agreement

The conference agreement in general reflects the House provisions regarding effective dates with some modifications.

(18) Waiver of Paperwork Reduction Act (Section 9214(b) of Ways and Means; Section 4116(c) of Energy and Commerce)

Present law

The Paperwork Reduction Act provides that each Federal agency systematically inventory information systems and implement procedures for assessing their paperwork and reporting burden. They are also required to assure that any collection of information is not duplicative with other agencies. There are additional provisions relating to the Office of Management and Budget and the assessment of the paperwork burden of proposed legislation.

House bill

Section 9214(b).—Provides that the requirements of the Paperwork Reduction Act do not apply to information required for purposes of carrying out this legislation and implementing the amendments made by this legislation.

Section 4116(c).—Similar provision.

Senate amendment

No provision.

Conference agreement

The conference agreement includes both House provisions.

(19) Personal Needs Allowance (Section 4115 of Energy and Commerce)

Present law

Under the current Medicaid statute, once an aged, blind or disabled individual residing in a SNF, ICF or hospital has been determined to be eligible for Medicaid, much of the individual's monthly income is applied to the cost of care. However, some amounts, including an allowance for clothing and other personal needs, are reserved for the use of the individual while in an institution. This allowance must be at least $25 a month for an aged, blind or disabled individual and $50 a month for an institutionalized couple, if both spouses are aged, blind and disabled or their income is considered to be available to each other in determining eligibility. For other individuals, regulations specify a reasonable amount set by the State, based on a reasonable difference in their personal needs from those of the aged, blind or disabled.

House bill

Section 4115.—

(a) Requiring Increase in Personal Needs Allowance.—Makes technical changes to the Medicaid statute relating to the monthly personal needs allowance for certain institutionalized, non-SSI indi-

viduals and couples. Provides that to meet the requirement for providing a personal needs allowance, the State plan must provide that, in the case of an institutionalized, non-SSI individual or couple, that in determining the amount of the individual's or couple's income to be applied monthly to the cost of care in an institution, that there be deducted from the monthly income (in addition to other allowances provided by the State plan) a monthly personal needs allowance which is reasonable in amount for clothing and other personal needs of the individual (or couple) while in the institution, and which is not less than the minimum monthly personal needs allowance. Provides that the minimum monthly allowance for 1988 is $35 for an institutionalized individual and $70 for an institutionalized couple (if both are aged, blind or disabled and their incomes are considered available to each other in determining eligibility.

Provides for a cost-of-living adjustment (rounded to the next highest multiple of $1) in following years, effective in Decembe of the previous year.

(b) Definitions.—Defines "institutionalized, non-SSI individual or couple" to mean an individual or married couple who is an inpatient in a hospital, SNF or ICF for which payments are made under Medicaid throughout a month, with respect to whom a SSI payment is not made under the Social Security Act, and who is determined to be eligible for medical assistance under the State plan.

Effective Date.—Applies to Medicaid payments on or after Jan. 1, 1988, without regard to whether or not final regulations have been promulgated. Provides that, for a State plan which the Secretary determines requires State legislation (other than legislation appropriating funds) in order to meet the additional requirements imposed by this provision, the plan is not to be regarded as out of compliance until immediately after the close of the first regular session of the State legislature that begins after the date of enactment.

Senate amendment

No Medicaid provision. See related SSI provision, section 4065 "Increase in Personal Needs Allowance for SSI Recipients," of Senate bill.

Conference agreement

The conference agreement includes the Senate amendment contained in the Supplemental Security Income portion of the bill.

(20) Report on Nursing Home Compliance with New Requirements (Section 4117 of Energy and Commerce)

Present law

No provision.

House bill

Section 4117.—Requires the Secretary to report to Congress annually on the extent to which nursing facilities are complying with the requirements of this bill (relating to provision of services, residents' rights, administration and preadmission screening for the mentally ill and mentally retarded) and the number and type of

enforcement actions taken by the States and the Secretary under the enforcement process amendments to the Medicaid statute of this legislation.

Effective date.—Enactment.

Senate amendment

No provision, but see provision below creating National Commission on Long-Term Care.

Conference agreement

The conference agreement includes the House provision.

(21) Establishment of Grant Program to Promote Quality of Care in SNFs (Section 4051(b) of Senate amendment)

Present law

No provision.

House bill

No provision.

Senate amendment

(a) Creation of Grant Program.—Requires the Secretary to establish a program of grants to SNFs certified as Medicare providers to promote the development by SNF's of projects that enhance the quality of care or the quality of life of residents.

(b) Application Process.—Requires that a SNF that desires to receive a grant to implement such a project submit an application to the Secretary, at such time and in such form and manner as the Secretary may prescribe.

(c) Selection Process.—Requires that the Secretary take into account the following in determining which SNFs will receive grants: (1) the likelihood that the proposed project will achieve its stated objectives; (2) the likelihood that the proposed project will serve as a model for similar projects in other facilities; and (3) the degree to which the funds provided by a grant will be matched by funds from non-Federal sources; and (4) the support for the project by the ombudsman, the area agency on aging, nursing home residents and their families, nursing home staff, institutions of higher learning, and other providers of long-term care.

(d) Amount of Grants.—Limits a grant to a SNF under this provision to no more than $25,000 a year.

(e) Evaluation of Grant Program.—Requires a SNF receiving a grant to furnish to the Secretary such information as the Secretary may require to evaluate the project with respect to which the grant is made and to ensure that the grant is expended for the purpose for which it was made. Requires the Secretary to submit a report on the program to the Congress not later than 180 days after all projects receiving a grant under the program are completed.

(f) Authorization.—Authorizes to be appropriated from the Federal Hospital Insurance trust fund $2 million for each of fiscal year 1988, 1989, 1990.

Effective date.—Enactment.

Conference agreement

The conference agreement does not include the Senate amendment.

(22) National Commission on Long-Term Care (Section 4051(g) of Senate Finance)

Present law

No provision.

House bill

No provision.

Senate amendment

(a) Creation of the Commission.—Amends Part A of title XI of the Social Security Act (relating to general provisions) by adding the following requirements for a National Commission on Long Term Care.

(b) Organization and Membership.—Requires the Director of the Office of Technology Assessment to provide for the appointment of a National Commission on Long-Term Care (referred to as the "Commission") to be composed of independent experts appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service). Provides that the Commission consist of 13 members, to be first appointed no later than Oct. 1, 1988, for a term of 5 years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than 4 members expire in any one year.

Requires the membership of the Commission to provide expertise and experience in the provision and financing of long-term care. Requires the Director to seek nominations, and to select at least one member of the Commission, from each of the following categories: (1) Representatives of Federal and State licensing and certification agencies; (2) long-term care ombudsmen; (3) consumers; (4) representatives of organizations representing nursing homes; (5) representatives of home health agencies; (6) experts in long-term care policy; (7) registered professional nurses; (8) health care and allied professionals with experience relating to long-term care; (9) individuals representing organizations of employees of SNFs, ICFs, or home health agencies.

(c) Operation of the Commission.—Provides for application to the Long-Term Care Commission specified sections of the law relating to the Prospective Payment Assessment Commission.

(d) Purpose of Commission.—Provides that the purpose of the Commission is to advise the Congress with respect to (1) methods of assessing and ensuring quality of care in long-term care facilities and certifying such facilities and programs; (2) necessary and desirable changes in the programs for surveying and certifying such facilities and programs; (3) the costs, appropriate staffing, and reimbursement of such facilities and programs; (4) the effectiveness of Federal and State licensing and survey procedures and the enforcement of such procedures, and (5) maintaining and extending the access of individuals entitled to benefits under Medicare or Medic-

aid to long term care and home health services (including the effects of State certificate of need requirements). Also requires the Commission to investigate compliance with Federal Medicaid requirements in any State with long reimbursement rates for nursing home care that has a moratorium on nursing home beds.

(e) Required Meetings.—Requires the Commission to meet at least quarterly and to convene such work groups, conferences and public hearings as it considers necessary to assist in carrying out its responsibilities.

(f) Required Reports.—Requires that not later than Oct 1, 1990, the Commission submit to Congress and the Secretary a report setting forth recommendations with respect to (1) implemantation of a reimbursement system and staffing requirements for long-term care facilities under Medicare that is based on the level of patient needs or the acuity of a patient's condition, or both; and (2) methods of ensuring the access to long-term care of individuals entitled to long-term care benefits under Medicare, or under a State plan approved under Medicaid. Requires that not later than 9 months after the Commission submits its report, the Secretary submit to Congress proposed legislation to implement the recommendations set forth in the Commission's report.

(g) Additional Reporting Requirements.—Requires the Secretary to report annually to the Congress and the Secretary on the status of its studies and deliberations. Requires the report to set forth any recommendations that the Commission has developed in the preceding year with respect to matters relating to long-term care. Requires that, not more than 90 days after the Commission submits its first required report, the Secretary submit to Congress a report setting forth the manner in which the Secretary proposes to implement and recommendations set forth in the Commission's report accompanied proposed changes in law (if any) that the Secretary determines to be necessary to implement the Commission's recommendations.

(h) Authorization.—Authorizes to be appropriated from the Federal Hospital Insurance Trust Fund such sums as may be necessary to carry out the provisions of this section.

Requires the Commission to submit requests for appropriations in the same manner as the Office of Technology Assessment submits requests for appropriations, but accounts appropriated for the Commission shall be separated from amounts appropriated for the Office of Technology Assessment.

(i) Study of Compliance.—Requires the Commission to conduct a study of the compliance with Federal quality standards by nursing homes in States that the Commission selects that have low reimbursement rates for nursing homes under Medicaid and have moratoria or limits in effect on the number of nursing home beds.

Effective date.—Enactment.

Conference agreement

The conference agreement does not include the Senate amendment.

(23) Final Regulations Implementing COBRA Provisions Relating to Intermediate Care Facilities for the Mentally Retarded (Section 4051(h) of Senate Finance)

Present law

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, P.L. 99-272) provided that if the Secretary determined there were deficiencies with an ICF/MR, the facility could submit a plan to correct the deficiencies within 6 months, or submit a reduction plan for closing all or part of the facility within 36 months in order to eliminate any physical plant or staffing deficiencies. The Secretary was required to promulgate proposed implementing regulations within 60 days after enactment (April 7, 1986). Proposed regulations were promulgated on July 25, 1986, but final regulations have not been promulgated.

House bill

No provision.

Senate amendment

Requires the Secretary to publish final regulations within 30 days of enactment to implement the amendments made by section 9516 of COBRA of 1985. Provides that the regulations shall be retroactive to the date of enactment of COBRA.

Effective date.—Effective as if enacted on April 7, 1986.

Conference agreement

The conference agreement includes the Senate amendment.

F. MEDICAID

1. Medicaid Optional Coverage for Additional Low Income Pregnant Women and Children (Section 4101 of the House bill, Sections 4052(a), (d), and (f) of the Senate amendment)

Present law

(a) Optional Coverage.—OBRA (1986) allowed States, effective April 1, 1987, to offer Medicaid coverage to all pregnant women, infants up to age 1, and, on an incremental basis, children up to age 5 with incomes up to a State established level that does not exceed 100% of the Federal poverty line. For pregnant women, coverage is limited to pregnancy-related services and extends through 60 days following pregnancy. For infants and children up to age 5, coverage is identical to that offered such assistance recipients.

(b) State Option to Impose Premium.—Current law prohibits imposition of an enrollment fee, premium, or similar charge on services furnished to pregnant women or children.

(c) Certification of Medicaid Eligibility for Newborn Infants.—A child born to a woman eligible for and receiving Medicaid on the date of the child's birth is deemed eligible for Medicaid for one year so long as the child is a member of the woman's household and the woman remains eligible for assistance.

House bill

(a) Optional Coverage.—Permits States to extend coverage to pregnant women and infants (under one year of age) with incomes up to 185% of the Federal poverty line for the same family size.

(b) State Option to Impose Premium.—No provision.

(c) Certification of Medicaid Eligibility for Newborn Infants.—No provision.

Senate amendment

(a) Optional Coverage.—Permits States to extend coverage to pregnant women and infants (under one year of age) with incomes up to 160 percent of the Federal poverty line for the same family size.

(b) State Option to Impose Premium.—Requires the imposition of a monthly premium of $5.00 with respect to children and pregnant women covered under the optional coverage provisions (including those covered pursuant to Items 2 and 3 below) whose family income equals or exceeds 130% of the Federal poverty level for the same-sized family.

Prohibits States from requiring prepayment of the premium. Eligibility may not be terminated for failure to pay until such failure continues for at least 60 days. A State may waive the premium in cases of undue hardship. A State may use State or local funds from other programs for premium payments; such payments may not be counted as income to the individual.

(c) Certification of Medicaid Eligibility for Newborn Infants.—Specifies that during the period a child is deemed eligible under this provision, the Medicaid identification number of the mother is to serve as the identification number of the child. All provider claims are to be submitted and paid under this number (unless the State issues a separate identification number for the child).

Conference agreement

(a) Optional Coverage.—The conference agreement follows the House bill.

(b) State Option to Impose Premium.—The conference agreement follows the Senate amendment with a modification. States could, at their option, impose a monthly premium on pregnant women and infants covered under this provision. The amount of the premium could not exceed 10 percent of the amount by which the gross income of the pregnant woman or infant, less child care expenses, exceeds 150 percent of the Federal poverty level for a family of the relevant size.

(c) Certification of Medicaid Eligibility for Newborn Infants.—The conference agreement follows the Senate amendment.

Effective date.—Applies with respect to medical assistance furnished on or after July 1, 1988.

2. ALLOWING ACCELERATED COVERAGE OF CHILDREN UP TO AGE 5

(Section 4102 of the House bill, Section 4052(b) of the Senate amendment)

Present law

OBRA (1986) allowed States, effective April 1, 1987, to extend Medicaid coverage, to pregnant women and infants up to age one with incomes up to a State-established level that does not exceed 100% of the Federal poverty line. Beginning October 1, 1987, States may increase the age level for children by one in each fiscal year until all children up to age 5 are included. A State cannot elect to cover one age group unless children in all younger age groups are covered.

House bill

Permits States to accelerate coverage of children under age 5 by permitting them to cover children under age 2, 3, 4, or 5 (as selected by the State) who are born after September 30, 1983.

Senate amendment

Same as House bill, except adds an additional conforming change.

Conference agreement

The conference agreement follows the House bill.

Effective date

Applies to medical assistance furnished on or after July 1, 1988.

3. COVERAGE OF CHILDREN UP TO AGE 8

(Section 4103 of the House bill, Section 4052(c) of the Senate amendment)

Present law

(a) *Mandatory coverage.*—States are required to extend Medicaid coverage to all children under age 5 born after September 30, 1983 who meet AFDC income and resources requirements.

(b) *Optional coverage.*—OBRA (1986) allows States to extend Medicaid coverage, effective April 1, 1987, to pregnant women and infants up to age one with incomes up to a State-established level that does not exceed 100% of the Federal poverty line. Beginning October 1, 1987, States may increase the age level by one in each fiscal year until all children up to age 5 are included. A State cannot elect to cover one age group unless children in all younger age groups are covered.

House bill

(a) *Mandatory coverage.*—Extends the mandatory coverage requirement to children under age 8 born on or after September 30, 1983. During FY89, the requirement applies to children under age 6 and during FY90, the requirement applies to children under age 7.

(b) *Optional coverage.*—Extends optional coverage of children by permitting States (in addition to the expanded coverage authorized under Item 2, above), to cover children under age 6, 7, or 8 (as selected by the State) who are born after September 30, 1983.

Senate amendment

(a) *Mandatory coverage.*—Extends the mandatory coverage requirement to children through age 6 born on or after September 30, 1983.

(b) *Optional coverage.*—Extends optional coverage of children by permitting States (in addition to the expanded coverage authorized under item 2, above), to cover children up through age 8 (as selected by the State) who are born after September 30, 1983.

Conference agreement

(a) *Mandatory coverage.*—The conference agreement follows the Senate amendment.

(b) *Optional coverage.*—The conference agreement follows the Senate amendment.

Effective date

Applies to medical assistance furnished on or after July 1, 1988.

4. DEMONSTRATION PROJECTS TO IMPROVE ACCESS TO NEEDED PHYSICIAN SERVICES BY PREGNANT WOMAN AND CHILDREN

(Section 4104 of the House bill, Section 4105 of the Senate amendment)

Present law

(a) The Secretary has general authority to waive certain program requirements as necessary to conduct demonstration projects.

(b) States are required to meet certain statutory requirements in order to be eligible for Federal matching payments. Under the "freedom-of-choice" provision a beneficiary may obtain services from any provider or person qualified and willing to perform the service. Under the "comparability" requirement, services must be equal in amount, duration, and scope for all categorically needy groups (with certain exceptions, generally based on age).

House bill

(a) Authorizes the Secretary to provide for demonstration projects by States to reduce infant mortality and early childhood morbidity. The projects are to improve access to obstetricians and pediatricians for eligible pregnant women and children under Medicaid.

The projects are to incorporate innovative approaches to increasing participation of obstetricians under Medicaid by such means as:

(i) improving compensation by increasing payment rates, expediting reimbursement, and using innovative payment mechanisms including global fees for maternity and pediatric services (with guaranteed periodic payments);

(ii) assisting in securing, or paying for, medical malpractice insurance or otherwise sharing in the liability risk;

(iii) decreasing unnecessary administrative burdens in submitting claims or securing authorization for treatment;

(iv) guaranteeing continuity of coverage, and expediting eligibility determinations, for eligible pregnant women and children served by such physicians; and

(v) covering medical services to meet the needs of high-risk pregnant women and infants.

Specifies that the Federal matching rate for demonstration projects is to be increased by 25 percentage points over the amount otherwise applicable. In no case can the matching percentage exceed 90%.

(b) Authorizes the Secretary to waive Medicaid requirements to the extent necessary to implement the demonstration projects. The Secretary may not waive either the freedom-of-choice provision or the provision specifying allowed cost-sharing requirements, except the freedom-of-choice provision may be waived to enable a State to implement a primary care case management system.

Prohibits the Secretary from approving a demonstration project, or accompanying waiver, which reduces the amount, duration, or scope of Medicaid coverage or results in the loss of eligibility for persons otherwise eligible.

Provides that a State request for approval of a demonstration project (and any accompanying waiver) is deemed granted unless the Secretary, within 90 days of submission, either denies the request in writing or informs the State in writing of additional information needed. After receipt of the additional information, the request is deemed granted unless the Secretary denies the request within 90 days.

Provides that the Secretary may not approve demonstration projects that result in aggregate additional Federal expenditures exceeding $50 million in FY88. Amounts appropriated and obligated are available until expended.

Requires the Secretary to report to Congress not later than March 1, 1991, on the demonstration projects and how the results of the demonstration projects may be used to lower infant mortality through improving the access of indigent pregnant women and qualified children to needed physician services.

Senate amendment

(a) Provides that, upon application by the State of New York and approval by the Secretary, the State may conduct a demonstration project to test a Prenatal/Maternity/Newborn Care Pilot Program as an alternative to existing Federal programs. Persons receiving benefits under the program would not receive Medicaid benefits. Federal payments to the State for benefits provided by the program would be in the same amounts as would have been paid for the same benefits under Medicaid, as determined by the Secretary. The Secretary is authorized to waive any Medicaid requirements which would prevent effective operation of the program. The State is required to provide assurance to the Secretary that Medicaid benefits would be made available to pregnant women to the extent such benefits are not provided under the pilot project. The demonstration is to be conducted for a period not to exceed 3 years.

(b) No provision.

Conference agreement

(a) The conference agreement follows the Senate amendment with a modification. The provision specifies the waivers that the Secretary is authorized to grant in connection with the New York Pilot Program, requires a quality assurance program, and requires an evaluation of the demonstration.

Effective date

Enactment.

5. MISCELLANEOUS PROVISIONS RELATING TO SERVICES FOR PREGNANT WOMEN AND CHILDREN

(Section 4105 of the House bill)

Present law

(a) *Period of extended coverage for pregnant women.*—States are required to provide post-partum coverage to eligible pregnant women until the end of the 60-day period beginning on the last day of their pregnancy.

(b) *No application of AFDC deeming methodology.*—In determining eligibility of pregnant women and children under the optional coverage provisions, family income is to be determined in accordance with methodology employed by the State under the Aid to Families with Dependent Children (AFDC) or foster care programs and adoption assistance programs.

Under Section 1902(a)(17)(D) of the Medicaid law, only the income and resources of an applicant's spouse or an applicant's parent with respect to children who are under 21 or blind or disabled are considered (within certain limits) as available to the applicant.

(c) *Maintenance of effort date.*—States electing to cover pregnant women and children under the optional coverage provisions are prohibited from lowering their AFDC standard from that in effect on April 17, 1986.

(d) *No AFDC application required fo optional pregnant women and children.*—State agencies are required to obtain a written application from a Medicaid applicant or his representative. The agency must not require a separate application from an individual receiving AFDC.

House Bill

(a) *Period of extended coverage for pregnant women.*—Specifies that coverage extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

(b) *No application of AFDC deeming methodology.*—Specifies that the methodology of these programs is to be used except to the extent it is inconsistent with Section 1902(a)(17)(D) of the Social Security Act.

(c) *Maintenance of effort date.*—Changes the date to July 1, 1987.

(d) *No AFDC application required for optional pregnant women and children.*—Prohibits States from requiring applicants to apply for AFDC as a condition of receiving Medicaid under the optional coverage provisions.

Senate amendment

(a) *Period of extended coverage for pregnant women.*—No provision.

(b) *No application of AFDC deeming methodology.*—No provision.

(c) *Maintenance of effort date.*—No provision.

(d) *No AFDC application required for optional pregnant women and children.*—No provision.

Conference agreement

(a) *Period of extended coverage for pregnant women.*—The conference agreement follows the House amendment with a clarification that pregnancy-related services include family planning services.

(b) *No application of AFDC deeming methodology.*—The conference agreement follows the House bill.

(c) *Maintenance of effort date.*—The conference agreement follows the House bill.

(d) *No AFDC application required for optional pregnant women and children.*—The conference agreement follows the House bill.

Effective date

Items (a) and (b) effective as if they had been included in the enactment of Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272). Item (c) applies to elections made after enactment. Item (d) applies as if included in the enactment of the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509).

6. NURSING HOME REFORMS

(Sections 4111-4117 and 9311-9324 of the House bill, Section 4051 of the Senate amendment).

See discussion of Part 2, sections 4211 through 4218.

7. MEDICALLY NEEDY INCOME LEVELS FOR CERTAIN 2-MEMBER COUPLES IN CALIFORNIA

(Section 4121 of House Bill)

Present Law

For purposes of Federal matching, medically needy income levels can be no higher than 133⅓ percent of the State's AFDC cash payment level for a family of the same size without any income or resources. California has based its medically needy income levels for the elderly and disabled on the AFDC payment standard for a family of three.

House Bill

Permits California, for payments made on or after July 1, 1983, to use a specified medically needy income level for families consisting of two adults, at least one of whom is aged, blind, or disabled. This level may not exceed the AFDC payment level for a three person family, consisting of one adult and two children, without any income or resources. The income limitation established for these families may be greater than that applicable for other medically needy families in California.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

Effective Date

The provision is effective upon enactment.

8. HOME AND COMMUNITY-BASED SERVICES FOR THE ELDERLY

(Section 4122 of the House Bill; Section 4101(a) of the Senate Amendment)

Present Law

OBRA (1981) authorized waivers for the provision of home and community-based services (not including room and board) for individuals who would otherwise require care in a skilled nursing facility (SNF) or intermediate care facility (ICF). These are frequently referred to as "2176 waivers" after the comparable section in P.L. 97-35. Services authorized to be provided under a waiver include both those not available under the individual State's Medicaid plan and those not generally available under Medicaid because they are primarily nonmedical in nature.

House Bill

(a) *Statutory Waiver Provision.*—Establishes a new waiver authority, separate from the existing "2176" waiver authority. Under a waiver, Medicaid payments may be made for part or all of the cost of home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals 65 years of age or older with respect to whom there has been a determination that institutionalization would be required in the absence of such services.

(b) *Assurances.*—Specified that a waiver may not be granted unless the State provides assurances, satisfactory to the Secretary, that:

(i) Neccessary safeguards have been taken to protect patient health and welfare and to assure financial accountability for expended funds;

(ii) The State will provide an evaluation of the need for SNF of ICF care for aged persons who are entitled to Medicaid payments for SNF or ICF care, may require such service, or [and?] may be eligible for home and community based services under the waiver;

(iii) The individuals determined likely to require SNF or ICF care are informed of alternatives available, at their choice, under the waiver;

(iv) The State will provide annual information (consistent with a data collection plan of the Secretary) on the impact of the waiver on the program and beneficiaries; and

(v) Medicaid expenditures for SNF, ICF, and home and community based services under the waiver will not exceed the projected amount.

(c) *Waiver of other Medicaid requirements.*—Specifies that an approved waiver may include a waiver of existing State plan requirements relating to state-wideness, comparability, and income and resource rules applicable for persons living in the community. A waiver may provide that the maximum amount of post-eligible income which may be disregarded is equal to such amount disregarded for "2176" waivers.

(d) *Duration of waivers.*—Specifies that the State may terminate a waiver (with at least 60 days advance notice to the Secretary), at the beginning of any calendar quarter. The waiver is for an initial period of three years, and on request of the State, shall be extended for additional 5-year periods unless the Secretary determines the required assurances have not been met in the previous period.

(e) *Waiver services.*—Specifies that covered waivered services may include (to the extent consistent with written plans of care, subject to State approval) case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve.

(f) *Payment limits.*—Provides that Medicaid payment may not be made for SNF, ICF, and home and community-based services provided to aged persons in a State during a waiver year (whether or not the waiver is terminated during the waiver year) to the extent such payments exceed a projected amount. The projected amount for a waiver year is the sum of the following amounts as determined by the Secretary:

(i) the aggregate amount of Medicaid payments in the State for SNF and ICF services for the aged for the base year increased by the "nursing facility increase percentage"; and

(ii) the aggregate amount of Medicaid payments in the State for home and community-based services furnished to the aged in the base year increased by the "home care increase percentage". The term "home and community-based" services includes home health care services, services which may be covered under the waiver, and personal care services.

Specifies that the term "base year" means the most recent 4 calendar quarter period (ending before October 1, 1987) for which actual final Medicaid expenditures have been reported to and accepted by the Secretary as of January 31, 1988.

Defines "nursing facility increase percentage" and "home care increase percentage" as the "applicable annual percentage", compounded annually over the period (including fractions of a year before the first waiver year) beginning with the last month of the base year and ending with the last month of the waiver year. Specifies that the "applicable annual percentage" means 9% per year.

For purposes of the nursing facility increase percentage, beginning in FY1990, such percentage is 9% or if greater, the sum of the projected percentage increase in the "facility index" (from the month before the period to the last month of the period) and the projected percentage increase in the elderly population of the State over the period. For purposes of the home care increase percentage, beginning in FY1990, such percentage is 9%, or if greater, the sum

of the percentage increase in the "home and community-based services index" (from the month before the period to the last month of the period) and the projected increase in the elderly population of the State over the period.

(g) *Regulations.*—Requires the Secretary to develop methods of projecting (and issue regulation by July 1, 1989) on:

(i) The percentage increase in nursing facility costs based on a weighted marketbasket index for SNF and ICF services;

(ii) The percentage increase in home care costs based on a weighted marketbasket index for home health and home and community-based services; and

(iii) A State-specific projection for the percentage increase in the number of residents who are 75 years and older.

(h) *Waiver denials and approvals.*—No provisions.

(i) *Transition for existing waivers.*—Provides for temporary extension of an existing "2176" waiver for the elderly. The extension applies for such waivers which are in effect as of December 1, 1987, and which are scheduled to expire before July 1, 1988. The State is required to notify the Secretary, before expiration of its waiver, of its intention to file an application for a waiver under this new provision. The Secretary is required to extend approval of the "2176 waiver," on the same terms and conditions, through July 1, 1988.

Senate Amendment

(a) *Statutory waiver provision.*—Same as House bill.

(b) *Assurances.*—Same as House bill, except does not include item (v).

(c) *Waiver of other Medicaid requirements.*—Same as House bill.

(d) *Duration of waivers.*—Same as House bill, except that a State may terminate a waiver at any time.

(e) *Waiver services.*—Same as House bill, except also specifies that the waiver may limit the individuals provided benefits to those for whom the State determines there is a reasonable expectation that expenditures under the waiver will not exceed those that would be made in the absence of the waiver.

(f) *Payment limits.*—Similar general requirement. Defines the projected amount for a waiver year as the sum:

(i) the aggregate amount of Medicaid payments in the State for SNF and ICF services for the aged for the base year increased by the lesser of 7% or the sum of the following factors: (a) the percentage increase in the appropriate marketbasket index; (b) the percentage increase in the over age 65 population; and (c) 2% for each year beginning after the base year; plus

(ii) the aggregate amount of Medicaid payments in the State for home and community-based services for the aged for the base year increased by the lesser of 7% or the sum of the factors specified above.

Requires States to report expenditures on the basis of the specified age categories in order to be eligible for the waiver.

Specifies that the term "base year" means the most recent year (ending before enactment) for which actual final Medicaid expenditures have been reported to and accepted by the Secretary. "Base

year" means FY1989 in the case of a State that does not report age cohort expenditures for a year ending before enactment.

(g) *Regulations.*—No provisions.

(h) *Waiver denials and approvals.*—Specifies that a determination by the Secretary to deny a waiver (or extension of a waiver) is subject to administrative and judicial review. If the Secretary denies a request for a waiver extension, the waiver shall remain in effect for at least 90 days after denial or (after a State request for review) a final determination.

(i) *Transition for existing waivers.*—Same as House bill.

Conference agreement

(a) *Statutory waiver provision.*—The conference agreement follows the Senate amendment with technical amendments.

(b) *Assurances.*—The conference agreement follows the Senate amendment.

(c) *Waiver of other Medicaid requirements.*—The conference agreement follows the Senate amendment.

(d) *Duration of waivers.*—The conference agreement follows the Senate amendment.

(e) *Waiver services.*—The conference agreement follows the Senate amendment.

(f) Payment limits.—The conference agreement follows the Senate amendment.

(g) *Regulations.*—The conference agreement follows the House bill.

(h) *Waiver denials and approvals.*—The conference agreement follows the Senate amendment.

(i) *Transition for existing waivers.*—The conference agreement follows the Senate amendment.

Effective date

The provision is effective January 1, 1988.

9. PROTECTION OF INCOME AND RESOURCES OF COUPLE FOR MAINTENANCE OF COMMUNITY SPOUSE

(Section 4123 of House Bill)

Present law

(a) *In general.*—Eligibility of the aged and disabled for Medicaid is linked to actual or potential receipt of cash assistance under SSI. The SSI program employs certain criteria for the treatment of income and resources which are also used in states which cover all SSI recipients. (States which do not cover all SSI recipients may employ more restrictive criteria provided they are no more restrictive than those in effect in January 1972.)

An institutionalized individual with a spouse in the community is permitted to keep an amount for the maintenance needs of his spouse; however this amount is set at welfare levels. As a result of Medicaid rules, both for determining eligibility and in the treatment of income after eligibility has been established, the community-based spouse may become impoverished; this is referred to as spousal impoverishment.

(b) *Rules for treatment of income.*—Under SSI rules, if both spouses live together, their incomes and resources are considered available to each other whether or not actually contributed to each other. Spouses are no longer considered to be living together if one is institutionalized in a Medicaid institution longer than one month. Only the income of the institutionalized spouse is considered for purposes of determining eligibility. The "name on the instrument" rule applies in attributing income: i.e., income is considered to belong to the spouse whose name is on the instrument conveying the funds. (In the case of Social Security checks, the amount attributable to each spouse is the individual's share of the couple's benefit.)

(c) *Rules for Treatment of Resources.*—Resources must be considered mutually available for six months following institutionalization if both spouses are SSI eligible and for one month if only one spouse is SSI eligible. Countable resources above specified amounts must be applied to the costs of care. If resources are held solely by the institutionalized spouse, they are attributed to him for eligibility purposes. If they are held jointly by the institutionalized spouse, they are considered to belong entirely to the institutionalized spouse. If they are held solely by the spouse remaining in the community, none is considered available to the institutionalized spouse.

(d) *Protecting income of community spouse.*—After an institutionalized person has established eligibility, his income, after deduction of specified amounts known as "disregards," is applied to the cost of care. The disregards are applied to the patient's income in the following order:

(i) A monthly personal needs allowance (which must be at least $25);

(ii) A monthly maintenance needs allowance for an individual with a spouse at home which may not exceed: the SSI standard for an individual residing in his own home, the highest income standard for State optional supplementary payments, or the medically needy standard for one person. (A State not covering all SSI recipients cannot use a level higher than the more restrictive income standard or the medically needy standard);

(iii) An additional allowance for an individual with a family at home; and

(iv) Amounts for medical expenses not subject to payments by a third party.

(e) *Notice and hearing.*—No provision.

(f) *Court ordered support.*—In certain instances costs have issued orders against institutionalized spouses requiring them to make monthly payments to the community spouse. However, notwithstanding the order, the Health Care Financing Administration (HCFA) has determined that the income of the institutionalized spouse is available to him for purposes of determining his contribution to the cost of care.

(g) *Transfer of assets.*—The fair market value of any resources (not including the individual's home) disposed of within the preceding 24 months must be taken into account in determining SSI eligibility (to which Medicaid eligibility is linked). States are permitted, but not required, to impose such a restriction for Medicaid provid-

ed it is not more restrictive than that for SSI, with one exception. In cases where the uncompensated value of disposed resources exceeds $12,000, the State may provide for a period of ineligibility exceeding 24 months, provided the period bears a reasonable relationship to the uncompensated value. States may waive the delay in Medicaid eligibility in cases of undue hardship.

States are also allowed to deny Medicaid eligibility for 24 months to institutionalized persons who, within 24 months prior to application for Medicaid, disposed of their homes for less than fair market value even though such disposal would not make them ineligible for the SSI program. The provision does not apply if the individual intended to dispose of the home at fair market value or if title was transferred to a spouse or minor or handicapped child.

(h) *Conforming amendment.*—(i) Some States covering the medically needy use less restrictive income or resources methodologies than are applied under the SSI program. HCFA interpreted the law to require that States use SSI income and resource methodologies; however, pursuant to the Medicare Patient and Program Protection Act of 1987 (P.L. 100-93) HCFA can not take any compliance action during a moratorium period.

(ii) Medicaid law contains State plan requirements.

(i) *Study of means of recovering costs of nursing facility services from estates of beneficiaries.*—Under certain conditions, States may recover amounts paid on behalf of deceased beneficiaries.

House Bill

(a) In general

(i) Adds a new Section 1922 to the Act entitled "Treatment of Income and Resources For Certain Institutionalized Spouses." The provisions of this section supersede other provisions of Title XIX, to the extent they are inconsistent, for purposes of determining eligibility of an institutionalized spouse. Comparable treatment is not required for other groups of eligibles.

(ii) Specifies that, except as specifically provided, the section does not apply to the determination of what constitutes income or resources or the methodology and standards for determining and evaluating them.

(iii) Specifies that new Section 1922 applies to a State operating under a Section 1115 waiver (i.e. Arizona which is operating under an alternative demonstration program) but not to the commonwealths and territories.

(b) Rules for treatment of income

(i) Specifies that in any month in which a spouse is institutionalized, no income of the community spouse is considered available to the institutionalized spouse.

(ii) Specifies that, regardless of State laws relating to community property or division of marital property, the following income attribution rules apply (after the institutionalized spouse is determined eligible for Medicaid) for non-trust property unless otherwise specifically provided on the instrument. Income paid solely to one spouse or another is considered to belong to that respective spouse. If the income is paid in both names, half is considered available to

each spouse. If the income is paid in the name of either or both spouses and another person, the income is considered available to each spouse in proportion to the spouse's interest; if payment is made to both spouses, and no interest is specified, one-half is considered available to each spouse. The same principles apply for trust property unless the trust specifically provides otherwise (in which case the income is considered available to each spouse as provided in the trust). For non-trust property with no instrument, half of the income is considered available to each spouse.

(iii) An institutionalized spouse can rebut the non-trust property attribution rules by establishing that ownership interests are otherwise.

(c) Rules for treatment of resources

(i) Provides for the computation, as of the beginning of a period of continuous period of institutionalization, of total joint resources [and of the spousal share?]. All household good and personal effects are to be excluded from the calculation. The spousal share equals half of the total value.

Requires the State to provide an assessment and documentation of total joint resources at the request of either spouse, at the beginning of a continuous period of institutionalization. The assessment shall occur promptly on receipt of relevant documentation. A copy is to be provided to each spouse. A State may charge a reasonable fee for an assessment if it is not part of an application for Medicaid.

(ii) Provides that the determination of countable resources (at the time of application of benefits) is to be made regardless of state laws relating to community property or division of marital property. All resources held by either spouse are considered available to the institutionalized spouse, except that resources held in the name of the community spouse are not considered available unless they exceed the community spouse resource allowance (as of the application date.) [or, if greater, the amount retained under court order?]

(iii) No provision.

(iv) Provides that after an institutionalized spouse has established eligibility, no resources of the community spouse shall be considered available to institutionalized spouse.

(v) Specifies that if the spousal share is less than $12,000 (indexed to the CPI beginning in 1989), or a greater amount (up to $48,000) specified by the state, the institutionalized spouse is allowed to transfer a sufficient amount to enable the community spouse to hold the $12,000, or the amount specified by the State, in his or her own name. If the spousal share is greater than $48,000 (indexed by the CPI beginning for 1989), the amounts in excess of $48,000 would be attributed to the institutionalized spouse. A higher amount may be established pursuant to a fair hearing or court order.

(d) Protecting income for community spouse

Specifies that the following disregards are to be applied to the patient's income in the following order:

(i) A monthly personal needs allowance as specified under this bill ($35);

(ii) A community spouse monthly income allowance. The allowance is the amount needed to bring the community spouse's monthly income up to a minimum level [not to exceed $1,5000 (indexed to the CPI beginning for 1989), or a greater amount specified by the State] which is the sum of:

(a) 150% of the Federal poverty guidelines for a family of two;

(b) an excess shelter allowance (the amount by which mortgage expenses or rent, plus utility costs, exceed 30% of item "a"); and

(c) one-half of the amount by which the income of the institutionalized spouse exceeds the sum of items "a" and "b";

(iii) A family allowance for each family member (minor or dependent child, dependent parent or dependent sibling residing with the community spouse) equal to at least one-third of the amount by which 150% of the Federal poverty line for a family of two exceeds the family income of that family member; and

(iv) Amounts for incurred medical expenses not subject to payment by a legally liable third party.

(e) *Notice and hearing*

Requires specific notification to both spouses at the time of eligibility determination or to either spouse upon request. The State is required to provide notice with respect to: the community spouse monthly income allowance, the family allowance, the method for computing the amount of the community spouse resources allowance, and of the spouse's right to a fair hearing with respect to ownership and availability of income and resources and the determination of the community spouse monthly income allowance. If either spouse establishes that the minimum monthly maintenance needs allowance or the community spouse resource allowance (with respect to income generated) is inadequate to support the community spouse without financial duress, the amount is to increased.

(f) *Court ordered support*

(i) Provides that if a court has entered an order against an institutionalized spouse for monthly income support for the community spouse, the community spouse monthly income allowance must be at least as great as the court ordered amount.

(ii) Provides that if a court has entered a support order against an institutionalized spouse requiring the spouse to transfer countable resources to the community spouse, such transfer will not be considered in violation of transfer of assets prohibitions.

(g) *Transfer of assets*

Requires States to determine, at the time of application, whether an institutionalized individual has disposed, within the preceding 24 months, of resources for less than fair market value. If such a transfer has occurred, a period of ineligibility is established. The number of months in such a period equals the total uncompensated

value at the time of transfer divided be the average cost of nursing home care to a private patient in the State or community. The transfer prohibition does not apply if:

(i) the transfer was that of the applicant's home to his or her spouse, child under 21, or blind or disabled adult child;

(ii) resources were transferred to the community spouse or the individual's blind and disabled child;

(iii) a satisfactory showing is made either that:

(a) the individual intended to dispose of resources at fair market value or for other valuable consideration; or

(b) the resources were transferred exclusively for a purpose other than to qualify for Medicaid; or

(iv) The State determines that denial of eligibility would work an undue hardship.

States can only employ transfer of resources restrictions in accordance with these provisions.

(h) *Conforming amendment*

(i)Provides that a State's methodology for determining eligibility for the medically needy may not be more restrictive than that under the appropriate cash assistance program. The methodology is considered to be no more restrictive if, in using the methodology, additional individuals may be eligible and no otherwise eligible individuals are made ineligible.

(ii) Requires State plans to meet requirements pertaining to protection of community spouse and transfer of assets.

(i) *Study of means of recovering costs of nursing facility services from estates of beneficiaries*

Requires the Secretary to study the means for recovering amounts from the estates of deceased beneficiaries (or the estates of spouses of deceased beneficiaries) to pay for SNF or ICF services furnished them under Medicaid. The Secretary is required to report to Congress, not later than December 31, 1988, on such means, and include appropriate recommendations for change.

Senate Amendment

No provision.

Conference agreement

The conference agreement contains no provisions with respect to items (a) through (h).

(j) *Study of means of recovering costs of nursing facility services from estates of beneficiaries*

The conference agreement follows the House bill.

Effective date

Section (i) is effective upon enactment.

10. MEDICAID ELIGIBILITY OF WORKING WELFARE FAMILIES (4131 OF HOUSE BILL)

Present law

Medicaid coverage must be extended for four months to certain families whose cash assistance has been terminated. This extension applies to families who received AFDC for at least three of the preceding six months and who lost coverage due to increased income from or hours of employment.

States also must extend coverage for nine months to families losing AFDC because they no longer qualify for the four-monthly earned income. States have the option of extending this coverage for an additional six months to families who would be eligible for AFDC if the disregard were applied.

House bill

(a) Initial Six Month Extension

Requires States to extend Medicaid coverage for six months to families who received AFDC for at least three of the preceding six months and who lose coverage due to increased hours of or income from employment of the caretaker relative (as defined under the AFDC program).

Requires States to include with the AFDC termination notice a notice of the continuing availability of Medicaid and a description of the circumstances under which the extension may be terminated. The State is to include a card or other evidence of the family's continuing entitlement.

Provides that the extension shall terminate (after notice of the grounds for termination) after the first month in which the family ceases to include a dependent child. The State may not terminate assistance until it has determined the child could not be covered as a "Ribicoff child" or as a disabled person aged 18 or older.

Specifies that benefits available under the extension provision are the same as those which would be provided if the family were receiving AFDC.

At its option, a State may pay a family's expenses for premiums, deductibles, coinsurance, or similar costs for health insurance or other health coverage offered by an employer of the caretaker relative or the absent Parent of a dependent child (i.e., provide "wrap around coverage"). A State may require a caretaker relative, as a condition of coverage extension, to make application for such coverage but only if: (A) the caretaker relative is not required to make financial contributions for such coverage; and (B) the State provides directly, or otherwise, for payment for any premium, deductible, coinsurance, or similar expenses which the employee is otherwise required to pay. The State is to treat the coverage offered under the employer plan as third party liability (i.e. the State is required to make effort to recover any necessary payments). Payments for employer coverage are treated as Medicaid payments for purposes of Federal matching.

11. MEDICAID EXTENSION DUE TO COLLECTION OF CHILD OR SPOUSAL SUPPORT

(Section 4132 of House Bill)

Present Law

Medicaid coverage must be extended for four months to certain families who, between August 16, 1984 and September 30, 1988, lose AFDC because of receiving child or spousal support payments. This extension applies to families who were receiving AFDC for at least three of the preceding six months.

House bill

Requires States to provide Medicaid coverage, for an additional six months, to each dependent child and each relative with whom the child is living (including the relative's spouse) who become ineligible for AFDC because of collection of child support payments. Mandatory coverage is extended for those who received AFDC in at least three of the preceding six months.

Specifies that nothing in Section 417(a)(1) relating to case management services for families headed by a minor) shall be construed as requiring Medicaid case management services.

Specifies that an individual who would be receiving aid except for Section 417(b)(1)(A) (relating to living requirements for minor parents) is deemed to be receiving aid for Medicaid purposes.

Senate amendment

No provision.

Conference agreement

The Conference agreement does not include the House provision.

12. MEDICAID PAYMENTS TO THE COMMONWEALTHS AND TERRITORIES

(Section 4141 of the House Bill; Section 4053 of the Senate Amendment)

Present Law

(a) Total Federal matching payments for Medicaid expenditures in a fiscal year are limited to:

Puerto Rico—$63,400,000.
Virgin Islands—2,100,000.
Guam—2,000,000.
Northern Marianas—550,000.
American Samoa—1,150,000.

(b) For the Medicaid program in American Samoa, the Secretary may waive all Medicaid requirements except the limit on total expenditures, the Federal matching percentage, and provisions relating to the basic types of services a Medicaid program may cover.

House bill

Increases the limits to:

Puerto Rico:
FY 1988—$79,000,000.

FY 1989—83,700,000.
FY 1990—88,600,000.
Virgin Islands:
FY 1988—$2,600,000.
FY 1989—2,750,000.
FY 1990—2,920,000.
Guam:
FY 1988—$2,500,000.
FY 1989—2,650,000.
FY 1990—2,800,000.
Northern Marianas:
FY 1988—$750,000.
FY 1989—790,000.
FY 1990—840,000.
American Samoa:
FY 1988—$1,450,000.
FY 1989—1,540,000.
FY 1990—1,630,000.

The limits for FY 1990 remain in effect for each succeeding year.

Senate amendment

(a) No provision.
(b) Provides for a similar waiver authority for the Medicaid program in the Northern Mariana Islands.

Conference agreement

(a) The Conference agreement follows the House bill with an amendment raising the caps for the Commonwealths and Territories by a total of: $10.9 million in FY 1988, $14 million in FY 1989, and $17.1 million in FY 1990.
(b) The Conference agreement follows the Senate amendment.

Effective date

Provision (a) is effective commencing with payments made for fiscal year 1988. Provision (b) is effective upon enactment.

13. CLARIFICATION OF COVERAGE OF CLINIC SERVICES FURNISHED TO HOMELESS OUTSIDE FACILITY

(Section 4142 of House Bill; Section 4104 of Senate Amendment)

Present Law

Clinic services are among the optional benefits which States may elect to include among covered Medicaid services. HCFA has interpreted the law to limit payments for clinic services to those delivered in the clinic itself.

House bill

Provides that States may cover as clinic services those services furnished outside the clinic by clinic personnel to beneficiaries without a permanent residence fixed home, or mailing address.

(b) Mandatory 18-Month Extension

(i) Requires States to offer each family, receiving Medicaid for the entire six month initial extension period, the option of extending coverage for the succeeding 18 months.

(ii) *Notice.*—Requires each State during the third and sixth month of the initial extension period to notify the family of the option for a subsequent extension. The notice is to include a statement as to whether premiums are required, and a description of out-of-pocket expenses, benefits, reporting procedures, and coverage limitations under alternative coverage options. If the State requires a premium for extended assistance, it may require that the family report (not later than the 21st day of the 4th month of the initial extension period) gross monthly earnings, minus child day care costs, for the preceding three months. The reporting requirement only applies if it is described in the beneficiary notice. The notice in the 6th month must describe the premium amount applicable during the first three months of extended assistance.

(iii) *Termination.*—Provides that the extended assistance period shall terminate as follows:

(A) At the close of the first month in which the family ceases to include a child who would meet the definition of dependent child under AFDC.

(B) By the end of a month during which the family failed, by the 21st day, to pay the requisite premium for the preceding month (except where good cause has been established).

(C) by the close of the 1st, 4th, 7th, 10th, 13th, or 16th month of the extension period if:

(1) the family fails to report (not later than the 21st day of the month) gross monthly earnings, minus child day care costs, for the preceding three months (except where good cause established). The reporting requirement only applies if the family is so notified in the preceding month;

(2) the caretaker relative had no earnings in one more of the preceding three months (except where good cause established);

(3) the State determines that the family's average gross monthly earnings, minus child day care costs, for the preceding three months exceeds 185% of the Federal poverty line for the same size family.

Provides that instead of termination under (i) above, a State may provide for suspension of the extension until the month after the month the required reporting is made. Gross income information is subject to restrictions on use and disclosure as provided under AFDC. A redetermination of whether a family exceeds the gross income limit is required each time the family submits an earnings report.

Specifies that no termination can be made without a prior notice. Where the termination is based on no earnings by a caretaker relative, the notice must contain information on how the family can reestablish Medicaid eligibility.

Specifies that the State cannot terminate assistance for a child (based on a failure to report earnings) until it has determined that

the person is not eligible for medically needy coverage. [see page 401; prob. ok as is]

(iv) *Coverage.*—Requires each State to offer a family, which is eligible for extension coverage, either the same coverage offered to families on AFDC (with certain exceptions) or alternative coverage. A State may choose not to offer coverage for the following services: SNF, care furnishes by licensed practitioners within the scope of their practice under State law, home health, private duty nursing, physical therapy, other diagnostic and screening services for individuals over 65 in mental institutions, ICF, inpatient psychiatric services for persons under 21, hospice, respiratory care, and any other medical or remedial care recognized under State law.

Provides that a State may elect to pay a family's expenses for premiums, deductibles, coinsurance, or similar costs for health insurance or other health coverage offered by an employer of the caretaker relative or the absent parent of a dependent child subject to the same conditions as are applicable for such coverage under the initial extension period.

(v) *Alternative Coverage.*—Provides that the State may offer alternative coverage to caretaker and dependent childern by enrolling them in: (A) a family option of a group employer plan; (B) a family option of a group health plan or plans offered by a State to its employees; (C) a basic State health plan offered by the State to its uninsured population; or (D) an HMO (as defined under Medicaid), of which less than 50% of its membership is Medicaid eligible. This HMO option is not in lieu of the general HMO option under Medicaid. States may not provide "wrap around" coverage to individuals who enroll in a group employer plan.

Requires States to pay requisite premiums and other enrollment costs for any family it has elected to offer alternative assistance. Premium payments (excluding any amounts otherwise payable by an employer or amounts collected from beneficiaries) are considered as Medicaid payments for purposes of Federal matching.

Provides that if a State offers alternative coverage to families, it must offer them the option of enrolling or disenrolling during a one month period each year without cause. It must offer the option of disenrollment for cause at any time in the case of State uninsured plans or HMOs.

Prohibits, under alternative coverage options, cost-sharing for services related to pregnancy and ambulatory pediatric care (for children under age 8, born after September 30, 1983, as amended by item 1 above).

(vi) *Premiums.*—Permits States to impose premiums for extended coverage. The premium may vary by family size. The premium level may vary for each alternative option offered. In no case may the premium amount in a month exceed 10% of the amount by which the family's gross monthly earnings (excluding child day care costs) during the premium base period exceeds the minimum wage. The premium base period is defined as the 3-month period ending four months before the beginning of the premium payment period (which begins every 3 months).

(c) *Applicability.*—Specifies that the requirements for the extension periods applies to a State operating under a Section 1115 waiver but not to the commonwealths and territories.

(d) *Fraud.*—Provides that the section does not apply to persons losing cash assistance if the termination was due to fraud or imposition of a sanction.

(e) *Waiver.*—Authorizes the Secretary to waive compliance with Section 1902(a)(1) (relating to statewideness), 1916 (relating to cost-sharing requirements for nursing facilities) to the extent necessary for Washington State to carry out the demonstration project relating to the Family Independence Program (as added by an amendment reported by the Committee on Ways and Means to H.R. 1720).

Senate amendment

(a) *Initial Six Month Extension.*—No provision.

(b) *Mandatory 18-Month Extension.*—No provision.

(c) *Applicability.*—No provision.

(d) *Fraud.*—No provision.

(e) *Waiver.*—Section 4115 requires the Secretary to waive compliance with the compliance with the requirements of Sections 1902(a)(1), 1902(e)(1), and 1916 to the extent necessary to enable Washington State to carry out the Family Independence Program as enacted in May 1987 and approved under Section 4115.

Conference agreement

The conference agreement does not include the House provision with respect to items (a) through (c).

Waiver.—The conference agreement follows the House provision with a modification requiring the Secretary to grant the specified waivers if the Secretary approves the basic program.

Effective Date

Enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

Effective date

The provision applies to services furnished on or after January 1, 1988.

14. PHYSICIANS' SERVICES FURNISHED BY DENTISTS

(Section 4143 of House Bill; Section 4104 of the Senate Amendment)

Present Law

Physicians' services are among the mandatory services which State Medicaid programs must provide to categorically needy beneficiaries. For Medicaid purposes physicians' services do not include services furnished by a doctor of dental surgery or dental medicine. Coverage of dentists' services is optional.

House bill

Mandates Medicaid payments for services provided by a dentist or dental surgeon when the services are of a kind which, under State law, either a physician or a dentist may perform and which, if performed by a physician, would be covered as a physician service.

Senate amendment

Same as House bill.

Conference agreement

The Conference agreement follows the House bill.

Effective date

The provision is effective with regard to payments for quarters beginning on or after January 1, 1988, regardless of whether implementing regulations have been promulgated by that date. Delay is permitted where State legislation would be required in order to comply with the provision.

15. ADJUSTMENT IN MEDICAID PAYMENT FOR INPATIENT HOSPITAL SERVICES FURNISHED BY DISPROPORTIONATE SHARE HOSPITALS

(Section 4144 of House Bill)

Present Law

COBRA provided that State Medicaid reimbursement methods and standards for hospital services take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs.

House bill

(a) *Implementation of Requirement.*—Provides that a State Medicaid plan shall not be deemed to comply with the COBRA requirement unless the State has submitted to the Secretary, no later than April 1, 1988, a State plan amendment which includes a definition of "disproportionate share hospital" meeting the requirements of (b) and (d), below, and which provides for increases reimbursement for disproportionate share hospitals. Requires the Secretary to review the State plan amendments by June 30, 1988. A State whose amendment is disapproved for noncompliance is required to submit a revised amendment immediately.

(b) *Hospitals Deemed Disproportionate Share.*—Provides that a hospital shall be deemed a disproportionate share hospital if its Medicaid utilization rate exceeds 15 percent or its low-income utilization rate exceeds 25 percent. The Medicaid utilization rate is defined as the percent of a hospital's total inpatient days attributable to Medicaid eligibles. The low-income utilization rate is defined as the sum of two percentages: (1) Medicaid payment and State and local patient care subsidies as a percentage of the hospital's total patient revenues, and (2) inpatient charity care charges (excluding contractual allowances or discounts other than those for indigent patients ineligible for Medicaid) as a percentage of the hospital's total inpatient charges.

(c) *Payment Adjustment.*—Requires a State's Medicaid payment adjustment for a disproportionate share hospital to take the form of either: (1) a percentage adjustment in Medicaid payment for operating costs comparable to the adjustment which would be made under the Medicare rules for disproportionate share hospitals, or (2) a minimum specified additional payment or percentage, along with an increase in that payment or percentage proportional to the percentage by which the hospital's Medicaid utilization rate exceeds 15 percent.

(d) *Requirement to Qualify as Disproportionate Share Hospitals.*—Provides that a hospital may be deemed a disproportionate share hospital for Medicaid purposes only if the hospital has at least 2 obstetricians with staff privileges who have agreed to furnish obstetrical services to Medicaid beneficiaries. The requirement does not apply to childrens hospitals, or to a rural hospital which does not offer nonemergency obstetrical services to the general population as of the date of enactment. In the case of a rural hospital, an obstetrician is defined as including any physician with staff privileges who performs nonemergency obstetrical services at the hospital.

Senate amendment

No provision.

Conference agreement

(a) The Conference agreement follows the House bill with an amendment barring the granting of a Section 1915(b)(4) waiver.

(b) The Conference agreement follows the House bill with an amendment which deletes the 15% Medicaid utilization rate test and substitutes a test of one standard deviation above the Statewide mean.

(c) The Conference agreement follows the House bill with amendments (1) requiring substantial progress each year to full compliance by fiscal year 1990 and (2) exempting New York State pooling arrangments.

(d) The Conference agreement follows the house bill with an amendment exempting urban as well as rural hospitals that do not offer nonemergency obstetrical services.

Effective date

Provisions (a) through (d) are effective upon enactment.

16. TREATMENT OF GARDEN STATE HEALTH PLAN

(Section 4145 House Bill; Section 4102 of Senate Amendment)

Present law

States may enter into comprehensive Medicaid prepaid risk contracts with Federally qualified HMOs and a variety of other independent entities. Beneficiaries enrolling in a Federally qualified HMO or certain organizations receiving Federal grant funds may be required to remain enrolled for a period of up to 6 months; the State may agree to continue payments to the HMO on behalf of an enrollee for up to 6 months even if the enrollee loses Medicaid eli-

gibility (these provisions are known as "lock-in" and "minimum enrollment period," respectively).

House bill

Provides that an undertaking by the New Jersey Medicaid agency may be considered as "having entered into a prepaid risk contract" with the agency, if the program established by the undertaking complies with the requirements for such contracts and is operated by a separate entity (which may be a subdivision of the agency), and if there is separate accounting for program funds. Provides that the undertaking shall be eligible for the lock-in and minimum enrollment period provisions.

Senate amendment

Same as House bill, except imposes four additional requirements on the program:

(i) The methodology for establishing capitation rates must ensure to the Secretary's satisfaction that total Federal matching payments will be less than would have been spent for the same services delivered on a fee-for-service basis to an actuarially equivalent population.

(ii) The State must provide for review of the entity by a PRO or other organization contracting with the Secretary for review of HMOs or CMPs under the Medicare program.

(iii) The undertaking is subject to the same approval and annual reapproval by the Secretary as a Medicaid HMO contract would be.

(iv) The undertaking is not eligible for a freedom-of-choice or other waiver under section 1915(b) or under section 1115. Provides that the undertaking shall be eligible for the lock-in and minimum enrollment provisions only if at least 25 percent of its members are not Medicaid or part B Medicare beneficiaries and only if any members for whom capitation payments are made by any government entity were offered alternative coverage of costs that would have been paid by any government entity at the time such members were enrolled.

Conference agreement

The Conference agreement follows the Senate amendment.

Effective date

The provision is effective upon enactment.

17. FURTHER CLARIFICATION OF FLEXIBILITY FOR STATE MEDICAID PAYMENT SYSTEMS FOR INPATIENT SERVICES

(Section 4146 of House bill)

Present law

State Medicaid reimbursement methods for hospital and nursing home services must assure that payments (1) are based on rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities, and (2) are consistant with efficiency, economy, and quality of care. The

Secretary has provided by regulation that, in the aggregate, a State's Medicaid payments for these services may not exceed the estimated aggregate payment which would have been made if the State had followed Medicare reimbursement rules.

House bill

Provides that the Secretary has no authority to require that Medicaid payments to hospitals, skilled nursing facilities, or intermediate care facilities be limited, whether on an aggregate, facility-specific, or other basis, to the estimated amounts which would have been spent under Medicare principles.

Senate amendment

No provision.

Conference agreement

The Conference agreement does not include the House amendment.

18. TECHNICAL AND MISCELLANEOUS AMENDMENTS

(Section 4147 of House bill, Sections 4055, 4101(B) and (D); Section 4103 of the Senate amendment)

Present law

(a) *Section 2176—Waiver Technicals.*—Section 2176 of the Omnibus Budget Reconciliation Act of 1981 (OBRA 81, P.L. 97-35) authorized the Secretary to grant waivers to States for the operation of Medicaid home and community based services programs. The Secretary was authorized to waive a provision of the State Medicaid plan. OBRA additionally authorized waiver of a provision relating to comparability of services to be furnished to different classes of eligibles.

(b) *Increases in Number of Individuals Who May Be Served Under Model Home and Community-Based Service Waivers.*—A separate category of 2176 waivers, known as model waivers, was created by the Health Care Financing Administration (HCFA) to facilitate State efforts to provide community-based services to a limited number of blind and disabled individuals who would otherwise require institutional care and would be eligible for Medicaid if they were in an institution. Coverage under a model waiver is limited to no more than 50 such persons.

(c) *Katie Beckett Technical.*—For Medicaid purposes only, a State may deem eligible for Supplemental Security Income (SSI) or a State supplemental payment a disabled individual who is 18 years of age or younger, who requires the level of care provided in an institution and is receiving equally cost-effective care outside the institution, and who would be eligible for SSI or a State supplement if he or she were in an institution.

(d) *Codification of Voluntary Contribution Rule.*—A State Medicaid plan must provide for State financial participation in the non-Federal share of Medicaid expenditures. The Secretary has provided by regulation that private contributions may be counted towards

the State's share if the donated funds are entirely under the control of the State or a local Medicaid agency.

(e) *Organ Transplant Technical.*—States which choose to cover organ transplant procedures may restrict the facilities or practitioners from whom Medicaid beneficiaries may obtain the services, so long as the restrictions are consistent with accessibility of high quality care, and so long as similarly situated individuals are treated alike. States may restrict the facilities of practitioners from whom Medicaid beneficiaries may obtain the services, so long as the restrictions are consistant with accessibility of high quality care.

(f) *Emergency Care Technical.*—States are required, as a condition of granting Medicaid eligiblity, to obtain the applicant's Social Security number and to verify United States citizenship or satisfactory immigration status. Under the Omnibus Budget Reconciliation Act, states must provide Medicaid coverage to otherwise eligible illegal aliens for treatment of emergency medical conditions.

(g) *Civil Money Penalty and Exclusion Clarification.*—(i) Civil money penalties may be imposed in a number of circumstances in which a person makes a claim for payment which he or she knows "or has reason to know" is not valid.

(ii) The Medicare and Medicaid Patient and Program Protection Act (P.L. 100–93) provides that, when a provider is excluded from participation in the Medicare program for a specified period, the provider is also to be excluded from Medicaid participation for the same period, unless the Secretary grants a waiver of the Medicaid exclusion at the request of a State.

(h) *HMO Technical Amendments.*—A Federally qualified HMO participating in the Medicaid program is subject to the requirement that no more that 75 percent of its enrolled population be Medicare or Medicaid beneficiaries. This requirement may be waived for a Federally qualified HMO which was previously operated as a demonstration project and meets certain other conditions. However, an HMO receiving such a waiver is not eligible to participate in the lock-in and minimum enrollment period provisions (see the discussion of these provisions in item 16, above).

(i) *Incorporation of Certain Provisions Relating to Indian Health Service Facilities.*—Indian Health Services hospitals, intermediate care facilities, and skilled nursing facilities are eligible for Medicaid reimbursement if they meet certain qualifying conditions.

(j) *Frail Elderly Demonstration Project Waivers.*—OBRA required the Secretary to provide waivers of Medicare and Medicaid requirements for certain demonstration projects designed to replicate the ON LOK program, a previously authorized demonstration involving the provision of comprehensive health care to the elderly on a capitated basis. Eligibility for the waivers was restricted to projects which had received grants from the Robert Wood Johnson Foundation.

(k) *Medically Needy Incurred Expenses.*—Medically needy beneficiaries may qualify for Medicaid by incurring medical expenses sufficient to reduce their income and resources to levels established by the State's eligibility standards. Only medical expenses for which the applicant is actually liable may be counted as "incurred" for this purpose.

(l) *Qualifications for Case Managers for Individuals with Development Disabilities and Chronic Mental Illness.*—COBRA added as an optional Medicaid benefit case management services, defined as services to assist Medicaid eligibles in getting access to needed medical, social, and educational services. States may elect to provide case management to a specific population, such as individuals with chronic mental illness.

(m) *Habilitation Services Effective Date.*—State Medicaid programs may obtain waivers to furnish home and community based services to specified populations. COBRA permitted States to furnish "habilitation services," effective April 7, 1986; the definition covered only those services provided to individuals after discharge from an intermediate care or skilled nursing facility. The Secretary has interpreted the provision as allowing coverage of habilitation services only for waiver participants discharged from a facility on or after April 6, 1986.

(n) *Section 2176 Waiver for Institutionalized Developmentally Disabled.*—States applying for home and community based services waivers must provide assurances that average per capital expenditures during a fiscal year for persons participating in the waiver program will not exceed the average per capita Medicaid expenditures which would have been made for the same persons if the waiver had not been granted.

(o) *Renewal of Freedom-of-Choice Waivers.*—States may obtain waivers of the requirement that Medicaid beneficiaries be given free choice of providers in order to operate a primary care case management program or otherwise restrict provider participation. Waivers may be in effect for a maximum of two years; a waiver renewal application is deemed granted unless denied by the Secretary within 90 days after the date it is submitted.

(p) *Repeal of Coordinated Audit Requirement.*—When a Medicaid provider reimbursed on the basis of reasonable cost is also a Medicare provider reimbursed on the same basis, State audits to determine reimbursable costs must be coordinated with Medicare audits.

(q) *Medicaid Quality Review.*—State Medicaid programs entering into comprehensive risk contracts with HMOs or other prepaid providers must provide for an annual review of the quality of services furnished by each contractor. A State may use either a utilization and quality control peer review organization (PRO) which has contracted with the Secretary for Medicare reviews, or a private accreditation body. If the State contracts with a PRO, the Federal matching rate for the contract expenditures is 75 percent, if the State uses a private accreditation body, the matching rate is 50 percent.

(r) *Codification of Technical Error Definition.*—Federal financial participation in State Medicaid expenditures may be reduced to the extent that a State makes erroneous expenditures in excess of allowable error rate. The Secretary has provided by regulation that technical errors in the State's eligibility determination process will not be counted if correction of the errors would not result in a difference in Medicaid expenditures.

(s) *Freedom of Choice.*—States may restrict the freedom of choice of providers by persons enrolled in a primary care case management program, a health maintenance organization, or a similar

entity. COBRA provided that, when enrollment occurred under a waiver program, enrollment could not entail any restriction of the freedom to choose a provider of family planning services.

Persons losing Medicaid eligibility but remaining enrolled in an HMO because of minimum enrollment provisions are entitled only to services furnished by the HMO.

(t) *Miscellaneous Technical Corrections.*—Current law contains a number of technical errors.

House bill

(a) *Section 2176 Waiver Technicals.*—Provides that the Secretary may also waive a requirement that income and resource standards used in determining eliqiblity for non-institutionalized medicalIy needy beneficiaries conform to the stands used for comparable categorically needy groups.

(b) *Increase in Number of Individuals who may be Served under Model Home and Community-Based Services Waivers.*—No provision.

(c) *Katie Beckett Technical.*—Replaces the requirement, that the child would have been eligible for SSI or a State supplement if the child were in an institution, with a requirement that the child would have been eligible for Medicaid if he or she were in an institution.

(d) *Codification of Voluntary Contribution Rule.*—Provides that private donations may be counted to wards the State's share of Medicaid expenditures if they are subject to the unrestricted control of the State.

(e) *Organ Transplant Technical.*—Provides that the special rules governing organ transplant coverage may not be construed as permitting a State to limit coverage in such a way that the services provided are not reasonable in amount, duration, and scope to achieve their purpose.

(f) *Emergency care technical.*—Provides that State need not obtain a Social Security number or verify satisfactory immigration status when providing Medicaid coverage to an alien for treatment of an emergency medical condition.

(g) *Civil money penalty and exclusion clarifications.*—(i) Replaces "has reason to know" with "should know" each time it occurs.

(ii) Provides that a State may exclude a provider from participation in the Medicaid program for a longer period than that for which the provider is excluded from Medicare participation.

(h) *HMO Technical Amendments.*—Provides that Federally qualified HMOs which have received a waiver of the 75 percent Medicare and Medicaid enrollment limit are eligible for the lock-in and minimum enrollment period provisions.

(i) *Incorporation of Certain Provisions Relating to Indian Health Service Facilities.*—Provides that an Indian Health Service facility other than a hospital, intermediate care facility, or skilled nursing facililty is also eligible for Medicaid reimbursement if it provides services of a type covered under the State's Medicaid plan. The Secretary may enter into an agreement with a State for reimbursement of Medicaid payments to an Indian Health Service facility for services provided to Indians.

(j) *Frail Elderly Demonstration Project Waivers.*—Deletes the requirement that projects receiving waivers be funded by the Robert Wood Johnson Foundation, and requires instead that projects be part of an organized initiative to replicate the findings of the On Lok demonstration. Clarifies that projects receiving waivers may assume risk progressively over 3 years.

(k) *Medically Needy Incurred Expenses.*—Provides that medical expenses may be counted as "incurred" for the purpose of establishing Medicaid eligibility even if the costs have been reimbursed under another State or local program.

(l) *Qualifications For Case Managers For Individuals With Development Disabilities and Chronic Mental Illness.*—Provides that, when a State furnishes case management services to individuals with developmental disabilities or chronic mental illness, it may restrict participation to case managers who are capable of ensuring that the individuals receive needed services.

(m) *Habilitation Services Effective Date.*—Provides that habilitation services may be pr6vided to any beneficiary participating in a home and community based services waiver program, regardless of whether her or she was receiving institutional services prior to participation; effective as if included in COBRA.

(n) *Section 2176 Waiver for Institutionalized Developmentally Disabled.*—Provides that, in making the required cost comparison for a waiver program which applies only to individuals with developmental disabilities who are inpatients in a skilled nursing or intermediate care facility (but who require the level of care provided by an intermediate care facility for the mentally retarded), the State may base its estimate of average per capita cost without the waiver on average per capita cost for inpatients of an intermediate care facility for the mentally retarded.

(o) *Renewal of Freedom-of-Choice Waivers.*—Provides that the Secretary may request additional information about a waiver renewal application within 90 days after the date of submission. Once the additional information is received, the application is deemed granted unless the Secretary denies it within 90 days.

(p) *Renewal of Freedom-of-Choice Waivers.*—Repeals the requirement for coordination of Medicare and Medicaid audits.

(q) *Medicaid Quality Review.*—Provides that a State may provide for review of prepaid contractors by an organization which meets the requirements established for PROs, but which has not contracted with the Secretary for Medicare reviews. Provides for a 75 percent matching rate for a contract with such an organization.

(r) *Codification of Technical Error Definition.*—Adds to the law the exception provided by regulation.

(s) *Freedom of Choice.*—Extends to non-waivered enrollment programs the prohibition of any restriction of freedom of choice among family planning providers.

(t) *Miscellaneous Technical Corrections.*—Makes technical corrections to various provisions. In provisions referring to "nonfarm" Federal poverty levels, strikes the word "nonfarm." Provides that a 198— Omnibus Budget Reconciliation Act (OBRA) Medicare amendment, which provided that commissions to a group purchasing agent do not constitute kickbacks, also applies to Medicaid, effective as if included in OBRA.

Senate amendment

(a) *Section 2176 Waiver Technicals.*—Same as House bill.

(b) *Increase in Number of Individuals who may be Served under Model Home and Community-Based Service Waivers.*—Prohibits any waiver for home and community-based services from limiting to less than 200 the number of individuals who may be served.

(c) *Katie Beckett Technical.*—No provision.

(d) *Codification of Voluntary Contribution Rule.*—No provision.

(e) *Organ Transplant Technical.*—No provision.

(f) *Emergency Care Technical.*—No provision.

(g) *Civil Money Penalty and Exclusion Clarifications.*—No provision.

(h) *HMO Technical Amendment.*—No provision.

(i) *Incorporation of Certain Provisions Relating to Indian Health Service Facilities.*—No provision.

(j) *Frail Elderly Demonstration Project Waivers.*—No provision.

(k) *Mentally Needy Incurred Expenses.*—No provision.

(l) *Qualifications for Case Managers for Individuals with Developmental Disabilities and Chronic Mental Illness.*—No provision.

(m) *Habilitation Services Effective Date.*—Provides that the COBRA provision applies with respect to habilitation services furnished on or after enactment of COBRA regardless of the date of an individual's discharge from a skilled nursing or intermediate care facility.

(n) *Section 2176 Waiver for Institutionalized Development Disabled.*—No provision.

(o) *Renewal of Freedom-of-Choice Waivers.*—No provision.

(p) *Repeal of Coordinated Audit Requirement.*—No provision.

(q) *Medicaid Quality Review.*—Provides that the 75 percent matching rate applies to expenditures under a contract with a private accreditation body whether or not it meets the requirements for PROs.

(r) *Codification of Technical Error Definition.*—No provision.

(s) *Freedom of Choice.*—Similar provision. Also provides that Medicaid payment may be made to a provider other than the HMO for family planning services furnished to an enrolled beneficiary who would be ineligible but for the minimum enrollment period.

(t) *Miscellaneous Technical Corrections.*—Makes a technical correction in the numbering of one provision.

Conference agreement

(a) The Conference agreement follows the Senate Amendment.

(b) The Conference agreement follows the Senate Amendment.

(c) The Conference agreement follows the House bill.

(d) The Conference agreement does not include the provision from the House bill

(e) The Conference agreement follows the House bill. The Conferees note that a state may require a reasonable expectation of therapeutic benefit from an organ transplant provided such requirement is applied uniformly.

(f) The Conference agreement does not include the provision in the House bill.

(g) The Conference agreement follows the House bill.

(h) The Conference agreement follows the House bill with an amendment regarding waivers under Section 1915(b) and conforming HMO sanctions.
(i) The Conference agreement follows the House bill.
(j) The Conference agreement follows the House bill.
(k) The Conference agreement follows the House bill.
(l) The Conference agreement follows the House bill.
(m) The Conference agreement follows the Senate Amendment.
(n) The Conference agreement follows the House bill.
(o) The Conference agreement follows the House bill.
(p) The Conference agreement follows the House bill.
(q) The Conference agreement follows the Senate amendment.
(r) The Conference agreement follows the House bill with an amendment providing for expiration on 12/31/88.
(s) The Conference agreement follows the House bill with an amendment concerning the minimum enrollment period.
(t) The Conference agreement follows the House bill.

Effective date

Provision (a) is effective as if it were included in the Omnibus Budget Reconciliation Act of 1986 (OBRA 1986), P.L. 99-509. Provision (b) is effective as if included in the Tax Equity and Fiscal Responsibility Act of 1982, P.L. 97-248. Provision (c) is effective upon enactment. Provision (e) is effective as if it were included in OBRA 1986. Provision (g) is effective upon enactment. Provision (h) applies to health care services performed on or after enactment. Section (i) is effective as if it were included in OBRA 1986. Provision (j) applies to costs incurred after the date of enrollment. Provisions (k), (l), and (m) are effective as though they were included in the Consolidated Omnibus Budget Reconciliation Act, P.L. 99-272. Provision (n) applies to requests for continuation of waivers received after the date of enactment. Provision (o) applies to audits conducted after the date of enactment. Provisions (p) and (q) are effective upon enactment. Provision (r) is effective such that it applies to services furnished on and after July 1, 1988. Provision (s) is effective upon enactment. Provision (t) is effective as if it were included in OBRA 1986.

19. STUDY AND REPORT ON THE MEDICAL EXPENSES OF FAMILIES OF CHILDREN WITH SPECIAL HEALTH CARE NEEDS

(Section 4052(g) of Senate amendment)

Present Law

No provisions.

House Bill

No provisions.

Senate Amendment

Requires the Office of Technology Assessment to conduct a study and report to Congress by August 1, 1988 on the following:

(i) the number of children age 18 and younger who have high cost medical expenses exceeding $25,000 in a single year and

who have a chronic illness or disability which results in their being developmentally delayed or unable to perform one or more normal activities;

(ii) their aggregate annual medical expenses;

(iii) their medical diagnoses;

(iv) the age of onset of conditions and the expected duration of illness or disabilities;

(v) payment sources;

(vi) status and adequacy of insurance and out-of-pocket liability to family income;

(vii) relation of out-of-pocket liability to family income;

(viii) causes of out-of-pocket liability;

(ix) demographic profiles of families with such children.

Conference agreement

The Conference agreement does not include the Senate provision. However, the Conferees agreed to a joint request to the Office of Technology Assessment for a study on the subject matter contained in the Senate Amendment, eliminating any duplication of subjects already under study.

20. FEDERAL REVIEW OF STATE INSPECTION OF CARE DETERMINATIONS

(Section 4054 of Senate amendment)

Present law

States are required to have an effective program of medical review of the care of Medicaid patients in skilled nursing facilities, intermediate care facilities, and mental hospitals. The reviews are to determine; (1) the adequacy of the services available; (2) the necessity and desirability of continued institutionalization; and (3) the feasibility of meeting health care needs through alternative institutional or noninstitutional services. The state must make a quarterly showing satisfactory to the Secretary that it has in place an effective program of medical review. The Secretary reviews these showings and also conducts onsite surveys to validate the State's quarterly showings. Penalties apply if the State survey fails to review each Medicaid-eligible patient.

House bill

Repeals current requirement for medical review in SNFs and ICFs [See related provisions in Nursing Home Comparison: section 4113 of Energy and Commerce and section 9212 of Ways and Means provisions regarding validation surveys (item 15(g)); and section 4111(f) of Energy and Commerce Committee provisions regarding readmission screening and annual review of mentally ill and mentally retarded residents (item 7 (g) and (h)].

Senate amendment

Provides that the Secretary may, in such cases as he finds appropriate, conduct an independent medical review of the care of patients in mental facilities, skilled nursing facilities, or intermediate care facilities, including an assessment of the appropriateness of the State's determination of level of care requirements, the adequa-

cy of the services provided, and the State's efforts in communicating deficiencies to the facility and assuring corrective action. If the Secretary finds following the conduct of an independent medical review, that the State has failed to perform an effective medical review, Federal financial participation shall not be available for care provided by the facility for patients for whom and during the period for which the review was found to be ineffective. Where the Secretary's review is based on sampling procedures, the findings of the review may be projected to all parties similarly situated in the State.

Requires that a State's program of medical review include provision, found adequate by the Secretary, for the development of a corrective action plan of each facility with deficiencies and a description of the steps that will be taken by the State to assure that the facility acts expeditiously to implement the plan and correct the deficiencies addressed in the plan. Requires that the corrective action plan address both deficiencies in services provided to individual patients and deficiencies of the facility generally.

Provides that failure to review each person's care in a mental hospital, skilled nursing facility, and intermediate care facility would not require the Secretary to find a State's program of medical review unsatisfactory, so long as the number of patients who were not reviewed did not exceed the lesser of 10 patients or 2 percent of all Medicaid patients in the institution (or 1 patient in the case of an institution with 50 or fewer Medicaid patients.)

Conference agreement

The Conference agreement does not contain the provision in the Senate Amendment. See Nursing Home provisions. Follows the House bill.

21. OPTIONAL MEDICAID COVERAGE OF INDIVIDUALS IN CERTAIN STATES RECEIVING ONLY OPTIONAL STATE SUPPLEMENTARY PAYMENTS

(Section 4056 of Senate Amendment)

Present law

State Medicaid programs may cover one or more reasonable categories of persons receiving State supplementary payments (SSP) but not supplemental security income (SSI) payments, provided they would be eligible for SSI except for income. Optional supplementary payments must be available on a statewide basis, though there may be variations in the income standards used by political subdivisions. Regulations require that in computing countable income for State-administered payments, the State must use SSI deductions from income or more liberal deductions.

House bill

No provision.

Senate amendment

Permits States which administer eligibility for their SSP-only recipients to determine countable income based on deductions estab-

lished by the State which are more restrictive than the SSI standards.

Conference agreement

The Conference agreement follows the Senate amendment.

Effective date

The provision is effective upon enactment.

22. MEDICAID WAIVER FOR HOSPICE CARE FOR AIDS PATIENTS

(Section 4106 of Senate Amendment)

Present law

A hospice contracting with Medicare or Medicaid must provide assurances satisfactory to the Secretary that total days of inpatient care provided to beneficiaries will be no more than 20 percent of the total days during which the beneficiaries' election to receieve hospice services is in effect.

House bill

No provision.

Senate Amendment

Provides, for Medicaid services only, that a hospice may be allowed to exclude days of inpatient care provided to individuals with acquired immunodeficiency syndrome from the days counted towards the 20 percent inpatient day limit. The Secretary is required to establish procedures for making this allowance.

Conference agreement

The Conference agreement follows the Senate Amendment.

Effective date

The provision is effective upon enactment.

23. DELAY QUALITY CONTROL SANCTIONS FOR MEDICAID

(Section 4107 of Senate Amendment)

Present law

Both AFDC and Medicaid have ongoing quality control programs which are intended to reduce erroneous benefit payments below certain target levels. States whose error rates fall above target percentages are subject to fiscal sanctions. COBRA provided for studies of quality control programs. AFDC fiscal sanctions were suspended for the 24 month period beginning July 1, 1986.

House bill

No provision

Senate Amendment

Prohibits the Secretary from imposing quality control sanctions for prior Medicaid July 1, 1988.

Conference agreement

The Conference agreement follows the Senate Amendment.

Effective date

The provision is effective upon enactment.

24. TECHNICAL AMENDMENTS RELATING TO NEW JERSEY RESPITE CARE PILOT PROJECT

(Section 4108 of Senate amendment)

Present law

Medicaid does not currently cover respite care services except where provided under a home and community-based waiver approved by the Secretary under Section 1915(c). However, Section 9414 of the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509, OBRA) established a respite care pilot project under the Medicaid program in New Jersey. HCFA has interpreted Section 9414 to require a formal Waiver. To implement the pilot project, certain technical corrections to OBRA are considered necessary.

House bill

No provision.

Senate amendment

(a) *Conditions of agreement.*—Amends Section 9414(b) of OBRA by adding language providing that the State may submit a detailed proposal describing the project (instead of a formal waiver request) and that the State is required to use a post-eligibility cost-sharing formula based on the available income of participants with income in excess of the nonfarm income official poverty line (as defined by the Office of Management and Budget and revised annually.)

(b) *Definitions.*—Amends Section 9414(a) of OBRA to redefine eligible individuals for the pilot project as those elderly and disable persons: (1) whose income does not exceed 300% of the SSI standard (or, in the case of a couple dependent on a caregiver, whose combined incomes do not exceed this amount); and (2) who, at State option meet a State-established resource standard. Also provides a definition of "respite care services."

(c) *Provisions subject to waiver.*—Allows the Secretary to require the current low requirements relating to single standard for income and resource eligibility.

Conference agreement

(a) *Conditions of agreement.*—The Conference Agreement follows the Senate Amendment.

(b) *Definitions.*—The Conference Agreement follows the Senate Amendment with an amendment establishing a self-declaratory resource limit of $40,000.

(c) *Provisions Subject Waiver.*

Effective date

Provisions (a) through (c) are effective upon enactment.

25. CONTINUES ELIGIBILITY AND RESTRICTION ON DISENROLLMENT WITHOUT CAUSE FOR METROPOLITAN HEALTH PLAN HMO

(Section 4109 of the Senate amendment)

Present law

For Federally qualified HMOs and specified other organizations with prepaid contracts, a State may: (a) Continue payments to the organization for up to 6 months after the date of enrollment on behalf of a beneficiary who loses eligibility for Medicaid benefits; and (b) restrict a beneficiary's right to disenroll from the organization without cause for up to 6 months.

House bill

No provision.

Senate amendment

Provides that, for the purposes of the payment continuation and disenrollment restrictions, Metropolitan Health Plan, operated by the New York City public hospitals, shall be treated in the same manner as a Federally qualified HMO.

Conference agreement

The Conference agreement follows the Senate Amendment with an amendment regarding the authority to grant waivers under Section 1915(b) and conforming HMO sanctions.

Effective date

The provision is effective upon enactment.

26. RURAL IMPACT REGULATORY ANALYSIS

(Section 4001(c) of Senate amendment)

Present law

There is currently no requirement that the Secretary include, in a proposed final rule, an analysis of the regulation's impact on rural areas:

House bill

No provision. See Item 7(j), Part A for summary of Medicare provision.

Senate amendment

Requires the Secretary—whenever he or she publishes a general notice of proposed rulemaking for any rule or regulation proposed under Medicare, Medicaid, or the peer review organization program, that may have a significant impact on a substantial number of small rural hospitals—to prepare and make available for public comment an initial regulatory impact analysis.

Requires that analysis to describe the impact of the proposed rule or regulation on such hospitals and requires that, with respect to small rural hospitals, the matters required under Section 603 of

Title V, United States Code, be set forth with respect to small entities.

Requires the initial regulatory impact analysis (or a summary) to be published in the Federal Register at the time of the publication of general notice of proposed rulemaking for the rule or regulation.

Requires the Secretary—whenever he or she promulgates a final version of a rule or regulation for which an initial regulatory impact analysis is required by the above—to prepare a final regulatory impact analysis with respect to the final version of the rule or regulation.

Requires that analysis to describe the impact of the proposed rule or regulation on such hospitals and requires that with respect to rural hospitals the matters required under Section 603 of Title V, United States Code, be set forth with respect to small entities.

Requires the Secretary to to make copies of the final regulatory impact analysis available to the public and to publish, in the Federal Register at the time of publication of the final version of the rule or regulation, a statement describing how a member of the public may obtain a copy of such analysis.

Requires that if a regulatory flexibility analysis is required by Chapter 6 of Title V, United States Code, for a rule or regulation to which this subsection applies, then such analysis shall specifically address the impact of the rule or regulation on small rural hospitals.

Conference agreement

The Conference agreement follows the Senate Amendment with an amendment limiting the application of the provision to regulations directly affecting operations of small rural hospitals.

Effective date

The provision applies to regulations proposed more than 30 days after the date of enactment of this Act.

27. COLLECTION OF PAST DUE AMOUNTS OWED BY PHYSICIANS WHO BREACHED CONTRACTS UNDER THE NATIONAL HEALTH SERVICE CORPS SCHOLARSHIP PROGRAM

(Section 4021(i) of Senate Amendment)

Present law

The National Health Service Corps provides scholarship funds for health professions training in exchange for a promise to serve in a health manpower shortage area for a specified period of time (one year of service for each year of scholarship assistance received). If the physician breaches this agreement, the scholarship, plus a penalty, must be repaid.

House bill

No provision.

Senate amendment

(a) *Agreements.*—(i) Adds a new Section 1891 to the Social Security Act entitled: "Offset of Payments to Physicians to Collect Past-

Due Obligations Arising From Breach of Scholarship Obligations." The Section requires the Secretary to enter into an agreement with any physician who, by reason, of a breach of contract with the National Health Service Corps Scholarship Program, owes a past due obligation to the United States.

(ii) Requires the agreement to provide that:

(A) Deductions are to be made from amounts otherwise payable to the physician under Medicare and Medicaid, in accordance with a schedule agreed to by the Secretary and the physician, until the past-due obligation (and accrued interest) have been repaid;

(B) Payment under Medicare to these physicians can only be made on an assignment related basis; and

(C) If the physician does not provide a sufficient quantity of Medicare and Medicaid services to maintain the collection according to the agreement formula and schedule, or if the physician refuses to enter into an agreement or breaches any provision of the agreement, the Secretary must immediately inform the Attorney General. The Attorney General is required to immediately commence an action to recover the full amount of the past due obligation. The Secretary is required to bar the physician from Medicare and Medicaid until the entire past-due obligation has been repaid.

(D) Prohibits the Secretary from barring a physician from Medicare and Medicaid if the physician is a sole community physician or sole source of essential specialized services in the community.

(b) *Past Due Obligation.*—Specifies that a past-due obligation is any amount: (1) owed by a physician to the United States by reason of a breach of a National Health Service Corps scholarship contract, and (2) which has not been paid by the deadline established by the Secretary and has not been cancelled, waived, or suspended by the Secretary.

(c) *Collection Not Exclusive.*—Specifies that the new Section 1891 does not preclude the United States from applying other provisions of law otherwise applicable to obligations owed to the United States.

(d) *Collection From Providers and Health Maintenance Organizations.*—(i) Requires the Secretary to deduct past due obligations from payments to a provider, health maintenance organization (HMO) or competitive medical plan (CMP) in the case of a physician who owes a past-due obligation and is an employee of a provider (which has an agreement with Medicare) or of an HMO or CMP (with a contract with Medicare).

(ii) Specifies that the deduction cannot be made until 6 months after the Secretary notifies the provider, HMO or CMP of the amount to be deducted and the physicians to whom the deductions are attributable.

(iii) Specifies that such deduction relieves the physician of the obligation (to the extent of the amount collected) to the United States. The provider, HMO or CMP has a right of action to collect from the physician the deducted amount (including accumulated interest).

(iv) Specifies that no deduction shall be made if, within 6 months of the notice, the physician pays the past-due obligation or is no longer an employee of the provider, HMO or CMP.

(v) Requires the Secretary to apply these requirements in the case of a physician who is a member of a group practice if the group practice submits bills as a group.

(e) *Notification to and Agreement With the State Medicaid Agencies.*—Requires the Secretary to notify each Medicaid agency of a physician who owes a past-due obligation. If the physician receives (or is employed by any entity which receives) Medicaid payments, the Secretary is required to enter into an agreement with each State under which the amounts otherwise payable will be deducted as provided under (a) or (d) above. Deductions are to be made only from the Federal share of Medicaid payments. Amounts paid to the State are to be reduced accordingly.

(f) *Transfer From Trust Funds.*—Specifies that deducted amounts are to be transferred from the appropriate trust fund to the general fund of the Treasury and credited as payment of the named physician's past due obligation.

(g) *Medicaid Amendment.*—Requires States to make deductions as specified by the Secretary under (e) above. Deductions are to be made from the Federal share of Medicaid payments credited as payment of the named physician past-due obligation.

(h) *PHS Act Amendment.*—Amends the PHS Act to provide for collection of past-due National Health Service Corps scholarship obligations through Medicare and Medicaid payments.

Conference agreement

The Conference Agreement does not include the portions of the Senate Amendment relating to Medicaid.

28. EXTENSION OF ARIZONA HEALTH CARE DEMONSTRATION PROJECT

(Section 4122 of the Senate amendment)

Present law

The Arizona Health Care Cost Containment System (AHCCCS) receives Federal matching, under the Section 1115 demonstration authority, for care it provides to categorically needy individuals who would be eligible for Medicaid in another State. This demonstration authority expires September 30, 1988.

House bill

No provision.

Senate amendment

Specifies that notwithstanding limitations included in Section 1115 of the Social Secuity Act, the Secretary upon application shall renew until September 30, 1989, approval of the AHCCCS demonstration project including all waivers granted by the Secretary under such Section 1115 as of September 30, 1987. The Secretary's renewed approval is on the same terms and conditions that existed between the applicant and the Secretary on September 30, 1987. The renewed approval remains in effect through September 30,

1989, unless the Secretary finds that the applicant no longer complies with such terms and conditions. Nothing in this provision is to be construed as preventing the applicant from seeking approval, in due course, from the Secretary for additional Section 1115 waivers for coverage of additional optional groups and for coverage for long-term care and other services which were not covered as of September 30, 1987.

Conference agreement

The Conference agreement follows the Senate Amendment with an amendment: providing that the extension is not to be construed as requiring or prohibiting the Secretary from granting further waivers regarding optional coverage groups or long-term care services.

Effective date

The provision is effective upon enactment.

29. CERTIFICATION AND RECERTIFICATION OF THE NEED FOR CERTAIN SERVICES

(Section 4131 of the Senate amendment)

Present law

(a) *Certification and Recertification for Certain Services.*—Payment for skilled nursing facility (SNF) services and intermediate care facility (ICF) services can only be made if a physician, or a physicians assistant or nurse practitioner working under the supervision of a physician, certifies and periodically recertifies that an individual requires services in an SNF or ICF. Such services also must be furnished according to a plan established and periodically reviewed by a physician.

(b) *Coverage of Certain Items and Services Provided by a Nurse Practitioner or Clinical Nurse Specialist.*—No provision.

House bill

(a) *Certification and Recertification for Certain Services.*—No provision.

(b) *Coverage of Certain Items and Services Provided by a Nurse Practitioner or Clinical Nurse Specialist.*—No provision.

Senate amendment

(a) *Certification and Recertification for Certain Services.*—Provides that the certification and recertification of the need for care in an SNF or ICF may be done by a physician, or by a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician. Also provides that the plan for SNF and ICF services must be established and periodically reviewed by a physician, or by a nurse practitioner or clinical nurse specialist who is not an employee of the facility but is working in collaboration with a physician.

(b) *Coverage of Certain Items and Services Provided by a Nurse Practitioner or Clinical Nurse Specialist.*—Provides for coverage of services provided in an SNF or ICF by nurse practitioners and clin-

in constructing its budget baseline for the purposes of that Act, the Congressional Budget Office and the Office of Management and Budget shall assume that the Federal Housing Administration mortgage insurance program is a permanent, ongoing program. This clarifies the law to conform with existing Congressional Budget Office and Office of Management and Budget practice.

TITLE IX—INCOME SECURITY AND RELATED PROGRAMS

A.—OASDI Provisions

EXTEND FICA TAX TO INACTIVE DUTY RESERVISTS

(Section 9001 of the House Bill Section 4588 of the Senate Amendment)

Present law

Wages paid for certain military training for the reserves are not subject to FICA tax.

House bill

FICA taxes would be extended to inactive duty training (generally weekend training).

Effective date.—The provision would apply with respect to services performed after December 31, 1987.

Senate amendment

Similar provision, except that the Senate amendment does not extend to inactive duty training the additional, general-revenue-financed social security wage credits which are provided for wages earned in active duty.

Conference agreement

The conference agreement follows the House bill, with the addition of the Senate amendment concerning additional military wage credits.

The provision would be effective with respect to * * * after December 31, 1987.

2. EXTEND FICA TAX TO WAGES OF CERTAIN AGRICULTURAL EMPLOYEES

(Section 9002 of the House Bill; Section 4587 of the Senate Amendment)

Present law

Cash wages paid by an employer to an employee for agricultural labor in any calendar year are subject to FICA tax only if (1) the employee received cash remuneration of at least $150, or (2) the employee performed 20 or more days of agricultural labor for that employer.

House bill

Provides that the 20-day test would be eliminated and that any remuneration for agricultural labor paid by an employer to an employee would constitute wages if the employer pays more than

$2500 to all employees for such labor during the taxable year. However, the $150 annual cash pay test would continue to be applied if the $2500 annual payroll test is not met.

Effective date—This provision would apply to remuneration paid for agricultural labor after December 31, 1987.

Senate amendment

Identical provision.

Conference agreement

The conference agreement follows the House bill.

3. FICA TAX APPLICATION TO EMPLOYER COST OF GROUP TERM LIFE INSURANCE

(Section 9003 of the House Bill; Section 4590 of the Senate Amendment)

Present law

The cost of group term insurance provided by an employer to an employee is excluded from wages for FICA purposes. For income tax purposes, the cost of employer-provided group term life insurance is includible in an employee's gross income to the extent that the coverage exceeds $50,000. Additionally the total amount of employer-provided group term life insurance is included in an employee's gross income if the coverage is provided on a discriminatory basis.

House bill

The cost of employer-provided group term life insurance is included in wages for FICA tax purposes if such insurance was includible for gross income tax purposes.

Effective date.—This provision applies to group term life insurance coverage in effect after December 31, 1987.

Senate amendment

Similar provision.

Conference agreement

The conference agreement follows the House bill.

4. COVERAGE OF SERVICES PERFORMED BY ONE SPOUSE IN THE EMPLOY OF ANOTHER

(Section 9004 of the House Bill; Section 4591 of the Senate Amendment)

Present law

Covered employment for FICA tax purposes does not currently include wages paid to a spouse in the employ of his or her spouse.

House bill

FICA tax is extended to wages paid for services performed by an individual in the employ of his or her spouse's trade or business.

Effective date.—The provision applies with respect to services performed after December 31, 1987.

Senate amendment

Similar provision.

Conference agreement

The conference follows the House bill, except the provision would be effective with respect to remuneration paid after December 31, 1987.

5. COVERAGE OF SERVICES PERFORMED BY AN INDIVIDUAL IN THE EMPLOY OF A PARENT

(Section 9005 of the House Bill Section 4592 of the Senate Amendment)

Present law

Wages paid for service performed by a child under the age of 21 in the employ of his or her father or mother are not subject to FICA tax.

House bill

FICA tax is extended to services performed by individuals between the ages of 18 and 21 who are employed in their parent's trade or business.

Effective date.—The provision applies with respect to services performed after December 31, 1987.

Senate amendment

Similar provision.

Conference agreement

The conference agreement follows the House bill, except the provision would be effective with respect to remuneration paid after December 31, 1987.

6. EXPAND EMPLOYER SHARE OF FICA TAX TO INCLUDE ALL CASH TIPS

(Section 9012 of the House Bill) (Section 4587 of the Senate Amendment)

Present Law

Special rules apply for purposes of calculating FICA taxes payable by employees and employers with respect to tips. For purposes of the employee FICA tax, tips received by employees are considered remuneration for services and are subject to the tax. The full amount of tips received by an employee is not, however, usually subject to the FICA tax imposed on the employer. Instead the employee is deemed to receive wages for purposes of the employer's share of FICA taxes only to the extent the Federal minimum wage exceeds the actual wage rate paid by the employer. Any tips received in excess of the difference between the minimum wage and the wages paid are not subject to the employer's portion of the tax.

House bill

For purposes of the employer's share of FICA taxes, all cash tips would be included within the definition of wages. Thus employers must pay FICA taxes on the total amount of wages and cash tips up to the Social Security wage base.

Effective date.—The provision would apply to tips received and wages paid on or after January 1, 1988.

Senate amendment

Identical provision.

Conference agreement

The conference agreement follows the House bill.

7. APPLICABILITY OF GOVERNMENT PENSION OFFSET TO CERTAIN FEDERAL EMPLOYEES

(Section 9006 of the House bill)

Present Law

Social security benefits payable to spouses of retired, disabled, or deceased workers are generally reduced to take account of any public pension the spouse receives as a result of work in a government job not covered by social security. The amount of the reduction is equal to two-thirds of the government pension. The offset does not apply to workers whose government job is covered by social security on the last day of the person's employment.

Generally, Federal workers hired before 1984 are part of the Civil Service Retirement System (CSRS) and are not covered by social security. Federal workers hired after 1983 are covered by the Federal Employees' Retirement System Act of 1986 (FERS), which includes coverage by social security. The FERS law provides that employees covered by the CSRS will be given the opportunity from July 1, 1987 to December 31, 1987 to make a one-time election to join FERS (and thereby obtain social security coverage). Thus, a CSRS employee who switches to FERS during this period immediately becomes exempt from the government pension offset.

House bill

Federal employees who switch from CSRS to FERS during the July 1-December 31, 1987 election period are exempt from the government pension offset only if they have 5 or more years of Federal employment covered by social security after June 30, 1987. Certain legislative branch employees mandatorily covered by social security by the 1983 Social Security Amendments are exempt only if they have 5 or more years of Federal employment covered by social security after December 31, 1983.

A transition rule is provided for those nearing retirement.

Effective date.—Applies with respect to benefits for months after June 1987, except for benefits to certain legislative employees mandatorily covered by social security by the 1983 Social Security Amendments who applied for spousal benefits before July 1, 1987.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill with a modification making the 5 year requirement effective prospectively; that is, it would be effective with respect to employees who elect to become covered under FERS during any election period which may occur on or after January 1, 1988. The provision also applies to certain legislative branch employees who first become covered under FERS on or after January 1, 1988. The provision would be effective with respect to social security benefits for months after December 1987 except for benefits to certain legislative employees who applied for special benefits before January 1, 1988.

8. EXEMPTION FROM REDUCTION IN "WINDFALL" BENEFIT

(Section 9007 of the House Bill)

Present Law

Under the so-called "windfall" benefit provision of the Social Security Amendments of 1983, social security benefits are generally reduced for workers who also have pensions from work that was not covered by social security (e.g., work under the Federal Civil Service Retirement System). Under the regular, weighted benefit formula, benefits are determined by applying a percentage to average indexed monthly earnings. In 1987, benefits equal 90 percent of the first $310 of average indexed monthly earnings, 32 percent of earnings from $310 to $1866, and 15 percent of earnings above $1866. The formula applicable to those with pensions from noncovered employment substitutes 40 percent for the 90 percent factor in the first bracket. (The second and third factors remain the same.) The resulting reduction in the worker's social security benefit is limited to one-half the amount of the noncovered pension. The new law is being phased in over a 5-year period beginning with those first eligible for social security benefits and noncovered pensions in 1986.

Workers who have 30 years or more of social security coverage are fully exempt from this treatment. For workers who have 26-29 years of coverage, the percentage in the first bracket in the formula increases by 10 percentage points for each year over 25, as illustrated below:

Years of social security coverage: First factor in formula	Percent
25 or less	40
26	50
27	60
28	70
29	80
30 or more	90

House bill

The years of social security coverage required in order for an individual to be exempt from the alternate benefit formula is lowered

from 30 to 25 years. Similarly, the years of coverage at which the formula gradually takes effect are scaled back, as illustrated below:

Years of social security coverage: First factor in formula	(Percent)
20 or less	40
21	50
22	60
23	70
24	80
25 or more	90

Effective date.—This provision is effective for benefits payable for months after December 1987.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

9. MODIFICATION OF AGREEMENT WITH IOWA TO PROVIDE COVERAGE FOR CERTAIN POLICEMEN AND FIREMEN

(Section 9008 of the House bill)

Present Law

Social security coverage for employees of State and local governments is optional. States elect coverage for themselves and their political subdivisions through agreements with the Secretary of Health and Human Services.

In 1986, the Iowa State Supreme Court held that the agreement between Iowa and the Secretary did not include certain police and firefighter positions. This decision effectively took away their coverage though they had paid FICA tax on their wages for many years.

House Bill

Allows the State of Iowa until 1989 to modify retroactively its agreement with the Secretary of Health and Human Services to provide coverage for certain police and firefighter positions.

Effective date.—Upon enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

10. INTERIM DISABILITY BENEFITS IN CASES OF DELAYED FINAL DECISIONS

(Section 9009 of the House bill)

Present law

If, upon appeal, an individual receives an unfavorable determination from an Administrative Law Judge (ALJ) at the hearing stage,

he or she may appeal to ALJ's decision to the Social Security Administration's Appeals Council. If the individual receives a favorable determination from an ALJ, the Appeals Council may review the determination on its "own motion." Interim disability benefits are not paid while a case is under review by the Appeals Council.

House bill

In any disability case under Title II or Title XVI of the Social Security Act in which an ALJ has made a decision favorable to the individual and the Appeals Council has not rendered a final decision within 110 days, interim benefits must be provided to the individual. (Delays in excess of 20 days caused by or on behalf of the claimant do not count in determining the 110 day period.) These benefits will commence with the month before the month in which the 110 day period expired and may not be considered overpayments if eligibility is subsequently denied, unless the benefits were fraudulently obtained.

Effective date.—The provision is effective with respect to favorable ALJ determinations made 180 days or more after enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

11. CONTINUATION OF DISABILITY BENEFITS DURING APPEAL

(Section 9010 of the House bill)

Present law

A disability insurance beneficiary who is determined to be no longer disabled can appeal the determination sequentially through three appellate levels within the Social Security Administration: a reconsideration usually conducted by the State Disability Determination Service that rendered the initial unfavorable determination; a hearing before an SSA administrative law judge; and a review by a member of SSA's Appeals Council.

The beneficiary has the option to have his or her benefits continued through the hearing stage of appeal. If the earlier unfavorable determinations are upheld by the ALJ, the benefits paid during the period of appeal are considered overpayments and are subject to recovery by the agency. (If an appeal is made in good faith, benefit repayment may be waived.) Medicare elibigility is also continued, but Medicare benefits are not subject to recovery.

This option was originally enacted in 1983 and has been extended twice. The latest extension, provided in Public Law 98-460, the Social Security Disability Reform Act of 1984, authorizes the payment of interim benefits to persons in the process of appealing termination decisions made before January 1, 1988. Such payments may continue through June 30, 1988 (i.e., through the July 1988 check).

House bill

The period in which benefits can be paid and Medicare eligibility continued while an appeal is in progress is extended for 1 year. Benefits may be paid while an appeal is in progress with respect to unfavorable determinations made on or before December 31, 1988 and may be continued through June 1989 (i.e., through the July 1989 check).

Effective date.—Upon enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill.

12. EXTENSION OF DISABILITY REENTITLEMENT PERIOD

(Section 9011 of the House bill)

Present Law

A disability insurance beneficiary can attempt to return to work under a so-called trial work period that can be up to 9 months long, provided his or her medical condition has not improved to the extent that he or she would no longer meet the definition of disability. Benefits are continued during this period. If in the 10th month, earnings constitute "substantial gainful activity" (currently earnings of $300 or more per month), cash benefits will be terminated two months later. In addition, a beneficiary who completes 9 months of trial work and continues to have a disabling impairment can have his or her benefits re-instated any time during the next 15 months (the reentitlement period) if the attempt at work fails (i.e., his or her earnings fall below $300) without the need for a new application and disability determination. Medicare eligibility continues for two years beyond the 15-month reentitlement period.

House bill

The period in which DI benefits can be reinstated is lengthened by 45 months, i.e., from 15 months to 60 months. As under current law, Medicare eligibility continues for two years beyond the 60-month reentitlement period.

Effective date.—The provision is effective January 1, 1988, and applies to individuals who are entitled to disability benefits after December 1987 and individuals who are within the 15-month reentitlement period.

Senate amendment

No provision.

Conference agreement

The Senate recedes to the House, with an amendment increasing the reentitlement period to 36, rather than 60, months. Medicare eligibility would continue for the 39 month period provided by current law (that is, two years past the previous 15 month reentitlement period).

13. FEES FOR REPRESENTATION OF CLAIMANTS IN ADMINISTRATIVE PROCEEDINGS

(Section 9021 of the House bill)

Present law

Attorneys often represent claimants who appeal decisions by SSA. Appealed decisions usually concern disability benefits. There are several layers of administrative appeal available before judicial review. At the Administrative Law Judge (ALJ) level, about 65 percent of the claimants are represented by attorneys.

The amount of the fee that an attorney or other person may charge a claimant for services performed as a representative in dealings with SSA must be approved by SSA. Section 206(a) of the Social Security Act requires that SSA set a "reasonable" fee as compensation for the attorney's services. If the claimant receives a favorable decision and become entitled to retroactive benefits, the Act also requires that SSA withhold part of the beneficiary's past-due benefits for payment directly to the attorney. The amount withheld must be the smaller of 25 percent of past-due benefits, the amount set by SSA, or the amount agreed upon by the attorney and the claimant.

Under administrative policy existing before April 1, 1987, ALJ's had the authority to approve an attorney's fee request of $3,000 or less. Above that amount, fee requests had to be approved by SSA's regional office (i.e., by a regional ALJ). Beginning on April 1, 1987, and continuing to December 16, 1987, SSA lowered this authority limit to $1,500. (The $3,000 limit was reinstated in a memorandum dated December16, 1987, from the Associate Commissioner of SSA to all ALJ's and supervisory personnel).

An individual's retroactive social security award may be reduced to take account of certain SSI, worker's compensation, or other public disability benefits that the individual has received. This reduction may result in insufficient past-due amounts being available to SSA for direct payment of the fee due to the attorney.

House bill

The payment of attorney's fees for representation of social security clients is changed from a fee petition process to an automatic payment system. Attorneys generally will be paid 25 percent of any back benefits awarded to the claimant, up to a cap of $4,000 (indexed to reflect increases in the cost of living). In cases where no back payment is due because benefits were paid during the appellate process, the attorney will receive 25 percent, up to the $4,000 cap, of the amount paid to the recipient through the period of representation. In cases where no back payment is due nor any benefits paid during appeal, the attorney will receive 3 times either: (1) the claimant's primary insurance amount; or (2) if benefits are paid based on another person's earnings record, the monthly benefit amount; or if less, $4,000. In cases where no back payment is due, the fee will be paid to the attorney by SSA and will be repaid by the beneficiary through withholding of 10 percent of future monthly benefits. In each case, the ALJ, the attorney, or the claimant may protest the 25 percent amount as too low or too high.

If there is a back award, the full amount of the award must be paid in the form of a two-party check, and sent to the attorney for division with the claimant. The attorney and the claimant must complete a sworn affidavit attesting that the attorney has received the correct fee. The attorney must send the affidavit to SSA within 15 days. Otherwise the authorization of the attorney's fee shall be withdrawn and the attorney shall be prohibited from representing claimants before SSA until the affidavit is sent.

An individual's retroactive social security award may not be reduced to take account of certain SSI, worker's compensation or other public disability benefits to the extent that the reduction would result in insufficient past-due amounts being available to SSA for direct payment in full of the fee due to the attorney.

Effective date.—Effective for determinations favorable to the claimant made after December 31, 1987.

Senate amendment

No provision.

Conference agreement

The conference agreement: (1) rescinds the $1,500 rule, (2) prohibits the issuance or amendment of any rules concerning the payment of attorneys' fees until July 1, 1989, and (3) requires simultaneous studies by the Department of Health and Human Services (to be conducted by the Social Security Administration) and the General Accounting Office of the process by which attorneys' fees are authorized and paid.

The rescission of the $1,500 rule is to apply prospectively to fees given final authorization by SSA on or after the date of enactment of this bill. The reinstated $3,000 limit is thus intended to apply to all future fee authorizations made by SSA including those in which, on or after the date of enactment of this bill, (1) benefits have been approved but a fee petition has not yet been submitted, (2) a petition in excess of $1,500 is pending before an ALJ or a regional chief ALJ, and (3) a fee authorized by an ALJ has been appealed by an attorney.

The SSA study will assess levels of reimbursement to attorneys, taking into account the contingent nature of most agreements between beneficiaries and their legal representatives, and propose alternative methods for establishing fees which take into account the nature of these agreements. It will also recommend changes which simplify and streamline the fee payment process. The GAO study will access the impact of the fee payment process on both beneficiaries and attorneys. It will include at a minimum an identification of obstacles to the timely payment of attorneys' fees and an assessment of the effects, if any, of the $1,500 limit on access to legal representation by applicants for social security disability benefits. Both studies must be submitted to Congress by July 1, 1988.

14. TREATMENT OF CORPORATE DIRECTORS AS EMPLOYEES FOR FICA TAX PURPOSES

(Section 9022 of the House bill)

Present law

Income from wages or self employment causes a reduction in social security benefits for recipients under age 70, if the income exceeds certain exempt amounts. Income from self employment for work performed after a person becomes entitled to social security benefits is counted in the year it is received. The wages of an employee, on the other hand, are counted in the year they are earned, regardless of when they are received.

Because corporate directors' earnings are treated as self-employment income, a director is able to avoid benefit reductions from the earnings test by deferring receipt of them until reaching 70. Since the earnings test does not apply to recipients age 70 and older, the deferred directorship earnings do not cause a reduction in benefits. In addition, since the earnings are deferred, the payment of SECA taxes is delayed; and the corporation is not responsible for either payment or withholding of FICA taxes on any remuneration to such individuals.

House bill

The provision amends the Social Security Act to treat directors of corporations as employees solely for purposes of the FICA tax and social security earnings test. This change is intended to be narrowly construed, and is not to be applied for other purposes.

Effective date.—This proposal is effective for remuneration paid on or after January 1, 1988.

Senate amendment

No provision.

Conference agreement

The conference agreement treats corporate directors' earnings as received when services are performed, regardless of when actually paid, for purposes of both the SECA tax and the earnings test.

15. APPLICATION OF EARNINGS TEST IN YEAR OF INDIVIDUAL'S DEATH

(Section 9023 of the House bill)

Present law

A Social Security beneficiary under age 70 with earnings in excess of certain thresholds is subject to a $1 reduction in benefits for every $2 earned over this exempt amount.

The annual exempt amount under the earnings test is lower for beneficiaries under age 65 than it is for beneficiaries ages 65–69. This year the under age 65 exempt amount is $6,000 and the age 65–69 exempt amount is $8,160. Thus, beneficiaries under age 65 begin to lose benefits at a lower earnings level than beneficiaries ages 65–69. If a beneficiary dies, the annual exempt amount applicable to his or her age group at time of death is prorated based on

the number of months that he or she lived during the year. Thus, if a 63 year old individual dies in October, the annual exempt amount is $5,000 (10/12 of the full year $6,000 exempt amount). In addition, the higher exempt amount is applicable in the year a beneficiary reaches age 65 regardless of when during the year the beneficiary turns 65. However, if a beneficiary dies at age 64 in the year that he or she would have turned 65, the lower exempt amount applies. If the beneficiary dies after his or her 65th birthday but still in the same year, the higher exempt amount applies.

House bill

The annual exempt amount is not prorated in the year of death. In addition, the higher annual exempt amount for recipients age 65–69 applies to people who die before they reach 65 in the year that they otherwise would have attained age 65.

Effective date.—Effective with respect to deaths after the date of enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

16. DENIAL OF BENEFITS TO INDIVIDUALS DEPORTED OR ORDERED DEPORTED ON THE BASIS OF ASSOCIATION WITH THE NAZI GOVERNMENT OF GERMANY DURING WORLD WAR II

(Section 9024 of the House bill)

Present law

People who are deported for violating specified provisions of the Immigration and Nationality Act lose their social security benefits. However, the list of provisions does not include paragraph 19. Paragraph 19, which was added to the Immigration and Nationality Act in 1978, pertains to people who are deported for certain activities in association with the Nazi government of Germany during World War II.

House bill

Benefits to individuals who are deported as Nazi war criminals under paragraph 19 of the Immigration and Nationality Act are terminated.

Effective date.—Applies only in the case of deportations occurring, and final orders of deportation issued, on or after the date of enactment, and only with respect to benefits beginning on or after such date.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

17. MODIFICATIONS IN THE TERM OF OFFICE OF PUBLIC MEMBERS OF THE BOARDS OF TRUSTEES

(Section 9025 of the House Bill)

Present law

The Boards of Trustees of the social security trust funds are composed of the Secretaries of the Treasury, Labor, Health and Human Services, and two members of the public. The members of the public are nominated by the President and confirmed by the Senate. The law specifies that their term of service is for four years, but is otherwise silent on the length of term for a public member appointed to fill a vacancy left by another public member who leaves before the end of his or her term, or on whether a public member is permitted to serve after the expiration of his or her term until a successor has taken office.

House bill

A public member appointed to fill a vacancy occurring before the end of a term shall serve only for the remainder of such term. Also a public member may serve after the expiration of his or her term until a successor has taken office.

Effective date.—Upon enactment.

Senate amendment

No provision.

Conference agreement

The Conference agreement does not include the House provision.

18. RAILROAD RETIREMENT TAX PROVISIONS

(Sections 9031–9033 of the House Bill and Sections 6582–6585 of the Senate Bill)

Present law

The Railroad Retirement Program consists of a Tier I benefit structure which is generally equivalent in benefits and financing to the social security program and a separately financed Tier II benefit structure. Under present law, the Tier II program is financed primarily by a payroll tax of 14.75 percent for employers and 4.25 percent for employees. This tax is applied to wages up to $33,800 in 1988. (This limitation on the amount of wages is increased annually by the increase in average annual wages in the general economy.)

Tier II benefits are includible in income for tax purposes in the same manner as benefits received under a qualified pension plan. The 1983 Railroad Retirement Solvency Act provides for the transfer to the Railroad Retirement Account of an amount equal to the income received from the taxation of Tier II benefits. This transfer to the Railroad Retirement Account is limited to an aggregate total of $877 million, and applies only to the taxation of benefits which are received prior to October 1, 1988.

House bill

(a) *Railroad retirement tax.*—The provision increases the employer Tier II tax by 1.35 percent to 16.1 percent. The employee rate is increased by 0.65 percent to 4.9 percent.

(b) *Commission on Railroad Retirement Reform.*—The provision establishes a seven-member Commission on Railroad Retirement Reform to perform a comprehensive study of alternative methods of financing the railroad retirement system. The study would look at the possibility of changes in the tax rate or base, the imposition of a tax on operating revenues, changes in investment policy, and the establishment of a private pension plan. In completing its study, the Commission would make findings relating to the economic outlook for the rail industry, and the nature of the relationships between the railroad retirement system, levels of rail employment and compensation, and the performance of the rail sector. The Commission would submit its report and recommendations to Congress by October 1, 1989.

(c) *Extension of transfer to the Railroad Retirement Account of Tier II taxes.*—No provision.

Effective date.—The railroad retirement tax increase is effective January 1, 1988.

Senate amendment

(a) *Railroad retirement tax.*—Same as House provision.

(b) *Commission on Railroad Retirement Reform.*—Same as House bill, except that provision establishes an eight-member commission.

(c) *Extension of transfer to the Railroad Retirement Account of Tier II taxes.*—The provision eliminates the $877 million limit on the amount of general funds that are transferred to the Railroad Retirement Account on the basis of income taxes on Tier II benefits. It also provides that such transfers will be made for two additional years based on Tier II benefits paid prior to October 1, 1990.

Effective date.—The railroad retirement tax increase is effective January 1, 1988.

Conference agreement

(a) *Railroad retirement tax.*—The conference agreed to the House bill and the Senate amendment.

(b) *Commission on Railroad Retirement Reform.*—The conference agreement follows the House bill with modifications. The President would appoint four members of the Commission, one of whom would represent rail labor, one of whom would represent rail management, one of whom would represent commuter railroads, and one of whom would represent the general public. The President pro tempore of the Senate and the Speaker of the House of Representatives would each appoint one public member. The Comptroller-General of the United States would appoint one public member with expertise in the fields of retirement systems or pension plans.

The conference agreement provides for the appointment of a total of four individuals from among members of the public. The conferees believe that these individuals should be selected on the basis of their ability to represent the public interest, as well as the

interests of the employers, employees, and retirees who are immediately affected by the system. These appointees should include individuals who have specific knowledge of the issues involved in establishing and maintaining an actuarially sound retirement system. They should also include individuals who have an understanding of the history of and the outlook for the railroad industry. The conferees anticipate that those who have the responsibility of appointing members of the Commission will make every attempt to assure that the Commission will be balanced in its composition so that all interests will be fairly represented.

The Conferees expect that the Speaker of the House of Representatives and the President pro tempore of the Senate will consult with the Chairmen of the appropriate committees before making their appointments to the Commission.

It is the intention of the Conferees that the study will focus primarily on financing issues. In addition, the study will also consider the ability of the system under current law to pay benefits to current and future beneficiaries and the financial relationship of the system to the railroad unemployment insurance system, the social security system, and the general fund. The Conferees do not intend however, that the study make recommendations which will require the use of additional general revenues to finance the system.

It is the intention of the Conferees that the Commission consider the matter of benefits for divorced spouses of retired railroad workers. They note that under present law, divorced spouses of railroad workers do not have the same coverage they would have under social security.

The agreement provides that the members of the Commission will serve without compensation, but will be reimbursed for expenses. They will elect their own Chairman from among themselves.

The agreement authorizes $1 million to fund the Commission.

(c) *Extension of transfer to the Railroad Retirement Account of Tier II taxes.*—The agreement follows the Senate amendment except the transfer of revenue would continue for one year only, until October 1, 1989.

Aid To Families With Dependent Children

A. FRAUD CONTROL UNDER AFDC PROGRAM

(Section 9202 of House bill)

Present law

States are reimbursed with 50 percent Federal funds for the proper and efficient administration of the AFDC program. This includes the cost of any pre-prosecutorial fraud control activities.

House bill

The House bill authorizes 75 percent Federal funding for costs of a State's fraud control program. In addition, it would disqualify from eligibility recipients found to have intentionally violated the program as follows: for first offense, six months; second offense, 12 months; third offense, permanently.

The determination of intentional violation would be based on proof of intentionally (a) making a false or misleading statement; (b) misrepresenting, concealing, or withholding facts; or (c) committing any act that violates the AFDC program, the State's AFDC plan or any Federal or State law or regulation relating to AFDC. The determination could be made either through an administrative hearing or by a court. The State agency could combine hearings for alleged violations in the AFDC and food stamp programs when factual issues arise from the same or related circumstances.

Effective date.—October 1, 1987.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill with several modifications. First, statutory language is added to clarify that matching funds are available for cases in which an individual pleads guilty or nolo-contendere, as well as for cases requiring prosecution. Second, States would be required to provide written notice at application of the penalties for fraud under the AFDC program. Third, the purposes for which Federal matching funds may be used are clarified. Funds may be used for costs relating to the investigation, prosecution, administrative hearing and collection of fraudulent cases. Fourth, language has been added to clarify that the fraud control provision applies to intentional actions to obtain or increase benefit amounts. The types of activities to be covered are expected to parallel those covered under the food stamp program. Similarly, the procedures used to carry out the AFDC fraud control program, including the hearings process, are expected to parallel those currently in use under the food stamp program.

B. ASSISTANCE TO HOMELESS FAMILIES. (SECTION 9219 OF HOUSE BILL; SECTION 4121 OF SENATE AMENDMENT)

Present law

(a) States may operate an emergency assistance program for needy families with children (whether or not eligible for AFDC) if the assistance is necessary in order to avoid the destitution of the child or to provide living arrangements in a home for the child. The statute authorizes 50 percent Federal matching for emergency assistance furnished for a period not in excess of 30 days in any 12-month period. Regulations state that Federal matching is available for emergency assistance authorized by the State during one period of 30 consecutive days in any 12 consecutive months, including payments which are to meet needs which arose before the 30-day period or are for such needs as rent which extend beyond the 30-day period.

(b) AFDC regulations allow States to include in their State standards of need provision for meeting "special needs" of AFDC applicants and recipients. The State plan must specify the circumstances under which payments will be made for special needs.

(c) No provision.

House bill

(a) The Secretary of HHS would be prohibited from taking any action to prevent a State, prior to October 1, 1988, from furnishing emergency assistance without durational limitation during any period of 12 consecutive months, if such assistance is authorized by the State during a single period of 30 consecutive days in such 12-month period, including assistance to meet needs which arose before the 30-day period or needs such as rent which extend beyond the 30-day period.

(b) The Secretary of HHS would also be prohibited from taking any action to prevent a State, prior to October 1, 1988, from including in its standard of need, (either as a basic or a special need) an amount for shelter and related needs that varies according to geographic location, family circumstance, or the type of living accommodation occupied.

(c) A demonstration program would be authorized under which any State that provides for temporary shelter as a special need could submit an application to conduct a demonstration for the purpose of encouraging landlords to make permanent dwelling units available to needy families that otherwise require emergency assistance under title IV-A of the Social Security Act in the form of commercial or similar transient accommodations, and of testing a method of minimizing or eliminating the need for emergency assistance in the form of commercial or similar transient accommodations.

A demonstration would provide for the payment of rent (under lease with owners of permanent dwellings): for the first 12 months of the lease, at the rate payable for comparable commercial or transient accommodations under the emergency assistance program; and, for the remainder of the lease, at the applicable AFDC housing allowance. No lease could be entered into after September 30, 1989. Notwithstanding any provision of AFDC law or regulation, the full amount of rent payable for the first 12 months of a lease would be matched at the State's AFDC matching rate.

The Secretary would be authorized to approve an application if it appears likely that the proposed project will contribute significantly to the purpose of the demonstration.

Effective date.—Prohibitions on Secretarial action would be effective October 15, 1987. Demonstration authority would be effective November 20, 1987.

Senate amendment

(a) No provision.

(b) The Secretary of HHS would be prohibited from taking any action, prior to October 1, 1988, from including in its standard of need (as a special need for individuals who would otherwise be homeless) an amount for shelter and related needs that varies according to geographic location, family circumstance, or the type of living accomodation occupied.

(c) No provision.

Effective date.—The prohibition on Secretarial action would be effective December 1, 1987.

Conference agreement

The conference agreement is a substitute for the House and Senate provisions. It prohibits the Secretary of Health and Human Services, prior to October 1, 1988, from taking any action that would have the effect of implementing, in whole or in part, the proposed regulation published in the *Federal Register* on December 14, 1987 with respect to emergency assistance and need and amount of assistance under the program of Aid to Families with Dependent Children, and from taking any other action that would change current policy with respect to the matters addressed in the proposed regulation published on that date.

The conferees note that the tragic problem of widespread homelessness of families with children is a relatively new phenomenon in this Nation, and governments at all levels are experiencing difficulty in dealing with it. The Committee on Ways and Means and the Committee on Finance intend to hold hearings in the coming year on whether and how the current AFDC statute should be amended to respond to the problem of homeless families. The conferees emphasize that while this issue is being considered by the Committees, they expect the Administration to maintain current policies with respect to State reimbursement for costs incurred in serving the homeless under the AFDC program.

C. WASHINGTON STATE DEMONSTRATION PROGRAM

(Section 4115 of Senate amendment)

Present law

The State of Washington has passed legislation to undertake a five-year demonstration program, the Family Independence Program (FIP), as an alternative to the present Aid to Families with Dependent Children program. The legislation directs the Governor to enter into agreements with the Federal government to allow the State to proceed with the program. The Governor must submit those agreements and an implementation plan to the legislature by no later than February 7, 1988. The demonstration cannot proceed without Federal authorizing legislation.

House bill

No provision. (A similar provision is contained in H.R. 1720.)

Senate amendment

The Senate amendment would allow the State of Washington to conduct a demonstration of its proposed Family Independence Program. The demonstration would emphasize education, employment and training services. The State would be required to provide assurances satisfactory to the Secretary that the total amount of Federal reimbursement over the period of the project will not exceed the anticipated Federal reimbursement under the AFDC and Medicaid programs (including reimbursement for additional persons who would qualify for AFDC, and for costs attributable to increases in the State's payment standard).

Every individual eligible for aid under the State AFDC plan would be eligible to enroll in FIP, which would operate simulta-

neously with the AFDC program so long as there are individuals who qualify for the latter. No family could receive less in cash benefits than it would have received under the AFDC program. Participation in work or training would be voluntary during the first two years of the program, and could thereafter by made mandatory only in counties where more than 50 percent of the enrollees can be placed in employment within three months after they are job ready.

Effective date.—Upon enactment.

Conference agreement

The conference agreement follows the Senate amendment, effective upon enactment.

D. NEW YORK STATE DEMONSTRATION PROJECT.

(Section 4114 of Senate amendment)

Present law

No provision.

House bill

No provision. (Identical provision included in H.R. 1720.)

Senate amendment

The Senate amendment would allow the State of New York to test a child support supplement demonstration program as an alternative to the present Aid to Families with Dependent Children (AFDC) program. The Federal government would pay to the State with respect to families receiving assistance under the demonstration program the same amounts as would be payable with respect to the families as if they were receiving cash and medical assistance under the regular AFDC and Medicaid programs.

The State would be required to provide assurances to the Secretary that the State will continue to make assistance available to all eligible children in the State who are in need of financial support, and will continue to operate an effective child support program. The State must also agree to have the program evaluated, and to report interim findings to the Secretary at such times as the Secretary provides. In addition, the State must satisfy the Secretary that the program will be evaluated using a reasonable methodology that can determine whether changes in earnings are attributable to participation in the program.

The State would be required to submit its plan for the demonstration to the Secretary of Health and Human Services for his approval. Unless the Secretary or the Governor choose to terminate the project sooner, the demonstration would be conducted for a period not to exceed five years.

Effective date.—Upon enactment.

Conference agreement

The conference agreement follows the Senate amendment, effective upon enactment.

II. Child Support Enforcement Amendments

A. CONTINUATION OF CHILD SUPPORT ENFORCEMENT SERVICES FOR FAMILIES NO LONGER RECEIVING AFDC

(Section 9231 of House bill)

Present law

State child support enforcement agencies are required to continue to collect child support payments on behalf of families that leave AFDC for a period of 3 months. After 3 months, if the State is authorized by the family to do so, it must continue to collect support without requiring the family to reapply as a non-AFDC case or to pay an application fee.

House bill

State child support enforcement agencies would be required to continue services for persons no longer eligible for AFDC on the same basis and under the same conditions as other non-AFDC families, except that no application (or application fee) for services could be required.

Effective Date.—Upon enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement follows the House bill, effective upon enactment.

E. CHILD SUPPORT SERVICES FOR CERTAIN FAMILIES RECEIVING MEDICAID.

(Section 9232 of House bill)

Present law

State child support enforcement agencies are required to petition for inclusion of medical support in child support orders (when health insurance is available to the absent parent at a reasonable cost) on behalf of AFDC recipients, non-AFDC families requesting child support services, and certain foster care families. As a condition of eligibility, all Medicaid applicants and recipients must assign to the State their rights to support (specified as support for the purpose of medical care by court or administrative order) and to payment of medical care from any third party. States are not required to extend child support services to Medicaid families who do not also receive AFDC.

House bill

State child support enforcement agencies would be required to provide services to all families with an absent parent who receive Medicaid and have assigned to the State their rights to support, regardless of whether they are receiving AFDC.

Effective date.—Upon enactment.

Senate amendment

No provision.

Conference Agreement

The conference agreement follows the House bill, effective July 1, 1988.

C. REPEAL OF CHILD SUPPORT REVOLVING FUND

(Section 4116 of Senate amendment)

Present Law

States may in specified circumstances request assistance from the Internal Revenue Service (IRS) in collecting child support obligations. When IRS makes a child support collection on behalf of a State, the monies collected must be deposited in a revolving fund. They are disbursed from the revolving fund to the State for further distribution as though the State had made the collection directly. Because of the existence of the fund, the monies flow through the Federal budget, although with no net budgetary impact, since income to the fund is offset by outgo from the fund. In the event of a sequestration under the Balanced Budget and Emergency Deficit Control Act, however, these monies would be subject to sequestration even though they are not Federal funds in any sense. Under the November 20th sequestration order, a total of $38,000 from this account is to be sequestered in fiscal year 1988.

House bill

No provision.

Senate amendment

The Senate amendment would replace the present revolving fund mechanism with a requirement that any amounts collected by IRS under this procedure be transferred to the State requesting the IRS assistance.

Effective date.—Upon enactment.

Conference Agreement

The conference agreement follows the Senate amendment, effective upon enactment.

III. C. Unemployment Compensation Amendments

A. RETROACTIVE CHANGE IN EFFECTIVE DATE OF CERTAIN EXTENDED BENEFIT REQUIREMENTS

(Section 9241 of House bill; Section 4120 of Senate amendment)

Present law

The Omnibus Reconciliation Act enacted in December 1980 gave States three months (to March 31, 1981) to enact laws requiring job search by individuals receiving extended unemployment benefits (which are partially funded out of the Federal unemployment tax). Sixteen States failed to enact legislation within the required time. The Inspector General of the Department of Labor has found them

out of compliance, and has determined that they should repay a total of $152 million to the Federal accounts in the trust fund.

House bill

The House bill would amend the 1980 Act retroactively to give States six additional months, until October 31, 1981, to come into compliance. States whose legislatures did not meet in 1981 are given until October 31, 1982, to come into compliance. The Congressional Budget Office considers the amendment to be budget neutral, because the $152 million would be shifted within accounts in the unemployment trust fund.

Effective date.—Upon enactment.

Senate amendment

The Senate amendment is the same as the House bill except that it provides for a compliance date of October 1, 1981 rather than October 31, 1981.

Conference agreement

The conference agreement follows the House bill.

B. SELF-EMPLOYMENT DEMONSTRATION PROGRAM

(Section 9242 of House bill; Section 4119 of Senate amendment)

Present law

Workers who become involuntarily unemployed are entitled to receive unemployment compensation benefits under State benefit programs. In general, benefits are available for up to 6 months of unemployment. To qualify for benefits, an individual must be able to work and must be available for work. If an individual attempts to set up his own business, he would be ineligible for further unemployment benefits since he would no longer be unemployed.

House bill

The House bill would authorize a demonstration project under which States would continue paying unemployment benefits to unemployed persons who attempt to set up their own businesses. A maximum of three 3-year demonstration projects would be authorized. In each State, the number of participants could not exceed the lesser of (1) 3 percent of the number of claimants receiving regular unemployment compensation at the start of the calendar year or (2) the number of individuals who exhausted unemployment benefits during the previous calendar year.

In order to participate in a self-employment project, a State would have to establish a project to assist claimants to set up businesses and would have to demonstrate that suitable conditions for creating new small businesses exist. States would have to establish the projects on a basis that would permit an estimate of the cost incurred or savings achieved. States would be required to guarantee that no net additional costs in any fiscal year would accrue to the unemployment program as a result of the projects. (State general revenues would have to be used to meet administrative costs

and to make up any losses to the unemployment compensation program.)

Effective date.—Upon enactment.

Senate amendment

Same as House bill.

Conference agreement

The conference agreement follows the House bill and the Senate amendment, effective upon enactment.

C. FUTA TAX EXTENSION

(Sections 9243-46 of House bill; Sections 4585-86 of Senate amendment)

Present law

The Federal Unemployment Tax Act (FUTA) imposes a gross employer tax of 6.2 percent on the first $7,000 paid annually to each employee. Employers in States with no overdue Federal loans are eligible for a full 5.4 percentage point credit, making the basic net FUTA tax rate 0.8 percent. The 0.8 percent tax rate has a permanent component of 0.6 and a temporary component of 0.2. The 0.2 percentage point surtax expires at the end of the year in which the Unemployment Trust Fund pays off an $8.7 billion debt incurred in the 1970s. Since this debt was repaid in May 1987, the 0.2 percentage point surtax is scheduled to expire at the end of 1987.

House bill

The 0.2 percentage point surtax is extended for 3 years. Half of the additional revenue collected during the extension flows into the Extended Unemployment Compensation Account and the other half goes into the Federal Unemployment Account.

In order to accumulate reserves in these accounts to help avoid future debt to the General Fund, the ceilings in these accounts are tripled from 0.125 percent to 0.375 percent of total covered wages.

If these accounts obtain new loans from the general fund, interest would be charged on the new loans. Currently, these loans are interest free. The interest rate is the same rate that is used to calculate interest on balances in the Unemployment Trust Fund. Interest payments by States on borrowing from the Federal Unemployment Account would be paid to that Account. Under present law, such interest is paid into the General Fund.

Effective date.—Wages paid on or after January 1, 1988.

Senate amendment

Same as House bill, except that the ceiling on the Federal Unemployment Account is increased from 0.125 percent to 0.625 percent of total covered wages and no provision is made for interest payments on loans from the General Fund.

Effective date.—Wages paid on or after January 1, 1988.

Conference agreement

The conference agreement follows the House bill except that it increases the ceiling on the Federal Unemployment Account to 0.625 percent of total covered wages as proposed in the Senate amendment.

IV. Supplemental Security Income (SSI)

A. PERMANENT EXTENSION OF DISREGARD OF CERTAIN IN-KIND ASSISTANCE

(Section 9201 of House bill; Section 4071 of Senate amendment)

Present law

In counting income for purposes of determining SSI benefits, the law requires exclusion of any support or maintenance assistance furnished to or on behalf of an individual that (as determined by the State) is based on need for such support or maintenance, including assistance received to help in meeting the costs of home energy (both heating and cooling), and that is (a) assistance furnished in-kind by a private nonprofit agency; or (b) assistance furnished by a supplier of home heating oil or gas, or by an entity providing home energy. States have the option to exclude this kind of assistance in determining AFDC benefits. This provision expired September 30, 1987.

House bill

The House bill would permanently extend the mandatory SSI disregard and the optional AFDC disregard of such in-kind assistance.

Effective date.—October 1, 1987.

Senate amendment

The Senate amendment is the same as the House bill except for a technical difference with respect to the effective date.

Conference Agreement

The conference agreement follows the House bill and the Senate amendment with an effective date of October 1, 1987.

B. EXCLUSION OF REAL PROPERTY WHEN IT CANNOT BE SOLD

(Section 9203 of House bill; Section 4069 of Senate amendment)

Present law

An individual may receive SSI benefits for a limited time even though he has property that, if counted, would make him ineligible. These benefits are conditioned upon the disposal of the property, and are subject to recovery as overpayments when the property is sold, or if the individual fails to dispose of them within the required time.

Regulations permit conditional payments for up to three months in the case of excess liquid resources that do not exceed $3,000 for an individual and $4,500 for a couple. In the case of real property,

regulations allow conditional payments for up to six months. There is no limit on the value of the real property which an individual can own and receive conditional payments.

SSI regulations also provide that property which no one has offered to buy within the conditional payment disposition period cannot be presumed to have zero market value and therefore not be counted as a resource. The regulations provide that the estimate of the property's market value remains operative unless the SSI recipient submits evidence which establishes a lower value.

House bill

The House bill would exclude from countable resources real property owned by an SSI recipient which cannot be sold because: (1) it is jointly owned (and its sale would cause undue hardship, including loss of housing, for the other owners); (2) its sale is barred by a legal impediment; or (3) the owner's reasonable efforts to sell it have been unsuccessful.

Effective date.—October 1, 1987.

Senate amendment

The Senate amendment would exclude (and does not require the sale of) real property for so long as it cannot be sold because: (1) it is jointly owned (and its sale would cause undue hardship due to loss of housing for the other owner or owners); (2) its sale is barred by a legal impediment; or (3) as determined by regulations issued by the Secretary, the owner's reasonable efforts to sell it have been unsuccessful.

Effective date.—The first day of the second calendar quarter to begin after the date of enactment.

Conference agreement

The conference agreement follows the Senate amendment, with an effective date of April 1, 1988.

C. TRANSFER OF ASSETS FOR LESS THAN FAIR MARKET VALUE

(Section 9204 of House bill; Section 4067 of Senate amendment)

Present law

When an individual gives away or sells an asset at less than fair market value, the value of that asset is counted for 24 months after disposal in determining whether the individual meets the SSI resource requirements, provided it is determined that the transaction was for the purpose of establishing eligibility for SSI. The transaction is presumed to have been for the purpose of establishing SSI eligibility unless the individual furnishes convincing evidence that it was exclusively for some other purpose.

House bill

The House bill provides that the value of resources given away or sold for less than fair market value in the prior 24 months may not be counted toward the SSI resource limit until the cumulative uncompensated value of such resources exceeds $3,000. It would also require the Secretary to issue regulations for suspending the

transfer of assets rule in cases where he determines that the suspension is necessary to avoid undue hardship.

Effective date.—October 1, 1987.

Senate amendment

The Senate amendment would require the Secretary of HHS to issue regulations for suspending the transfer of assets rule where he determines that the suspension is necessary to avoid undue hardship.

Effective date.—The first day of the second calendar quarter to begin after the date of enactment.

Conference agreement

The conference agreement includes only the provision which allows the Secretary of Health and Human Services to waive the SSI transfer of assets policy in cases of undue hardship, effective April 1, 1988. The conferees believe that the SSI transfer of assets policy should be coordinated with the Medicaid transfer of assets policy and expect that the two will be coordinated in the catastrophic health care bill which will be in conference during the second session.

D. EXCLUSION OF INTEREST IN BURIAL ACCOUNTS

(Section 9205 of House bill; Section 4070 of Senate amendment)

Present law

In determining whether an individual's resources are within the SSI eligibility limits ($1,800 per individual in counted resources in 1987) there is excluded an amount of up to $1,500 that is placed in a separately identifiable burial account, if the inclusion of any portion of the amount in the account would cause the individual's resources to exceed the SSI resource limit. Any interest earned on the excluded account also is excluded. If the person's resources are so low that the amount in the burial account would not cause ineligibility, any interest earned is not excluded.

House bill

The House bill would require that any interest on designated burial accounts must be excluded in determining whether an individual meets the SSI resource requirements, regardless of the amount of the individual's other resources.

Effective date.—October 1, 1987.

Senate amendment

The Senate amendment is the same as the House bill except for a technical difference.

Effective date.—The first day of the second calendar quarter to begin after the date of enactment.

Conference agreement

The conference agreement follows the Senate amendment, effective April 1, 1988. In addition, the conferees wish to clarify that the term "separately identifiable" as used in defining an excludable

burial fund means that the assets set aside as a burial fund must be kept separate from the individual's other assets and the fund must be specifically identified as to its purpose.

E. TREATMENT OF AFDC BENEFITS UNDER SSI RETROSPECTIVE ACCOUNTING

(Section 9206 of House bill; Section 4068 of Senate amendment)

Present law

When a recipient of Aid to Families with Dependent Children (AFDC) becomes eligible for SSI, his eligibility for AFDC is terminated. However, rules for determining the amount of an individual's SSI benefit require that the AFDC payment received in the month of application must be counted as income in determining SSI benefits for the first and second months after the month of application. This results in reduced SSI payments for those months, even though the individual's AFDC payments have actually been terminated.

House bill

The House bill would require that AFDC payments made by a State welfare agency be disregarded in determining SSI benefits.

Effective date.—October 1, 1987.

Senate amendment

The Senate amendment is the same as the House bill except for a technical difference.

Effective date.—The first day of the second calendar quarter to begin after the date of enactment.

Conference agreement

The conference agreement follows the House bill and the Senate amendment, with language clarifying that certain income will be counted only in the month it is received. This provision will apply to income received under title IV-A (AFDC), title IV-E (foster care), refugee cash assistance, Cuban/Haitian entrant assistance, or general and child welfare assistance provided by the Bureau of Indian Affairs. The provision is effective April 1, 1988.

F. TREATMENT OF CERTAIN COUPLES IN INSTITUTIONS

(Section 9207 of House Bill; Section 4074 of Senate Amendment)

Present law

States are allowed to treat a husband and wife who have shared a room in a Medicaid institution for a period of six months as a couple (rather than as two eligible individuals, as would otherwise be required under SSI rules) if doing so would prevent a reduction or termination of Medicaid benefits.

House bill

The House bill would expand this option to cover situations in which the husband and wife live in the same facility.

Effective date.—November 10, 1986.

Senate amendment

The Senate amendment is the same as the House bill.
Effective date.—Upon enactment.

Conference agreement

The conference agreement follows the House bill and the Senate amendment, effective November 10, 1986.

G. EXTENSION OF DEADLINE FOR CERTAIN WIDOW(ER)S TO APPLY FOR MEDICAID

(Section 9208 of House bill; Section 4079 of Senate amendment)

Present law

The 1983 social security amendments increased benefits for disabled widows and widowers. Because this benefit increase had the effect of making some individuals ineligible for SSI and therefore for Medicaid, a provision was later enacted to deem them to be SSI recipients for purposes of Medicaid eligibility. The law provided a 15-month period (to July 1, 1987) during which affected individuals could file an application for Medicaid under this provision.

House bill

The House bill would extend the period during which these persons may file an application for Medicaid to July 1, 1988.
Effective date.—July 1, 1987.

Senate amendment

Same provision.
Effective date.—Upon enactment.

Conference agreement

The conference agreement follows the House bill and the Senate amendment, effective July 1, 1987.

H. INCREASE IN SSI EMERGENCY ADVANCE PAYMENTS

(Section 9209 of House bill; Section 4066 of Senate amendment)

Present law

The Social Security Administration may make emergency advance payments of up to $100 to individuals who are presumptively eligible for SSI and who face a financial emergency.

House bill

The House bill would increase the allowable emergency advance payment to equal the maximum amount of the regular Federal SSI monthly benefit rate (currently $340 for an individual) plus, if any, the Federally-administered State supplementary payment.
Effective date.—October 1, 1987.

Senate amendment

Same provision.

Effective date.—The first day of the second calendar quarter to begin after the date of enactment.

Conference agreement

The conference agreement follows the House bill and the Senate amendment, effective upon enactment.

I. EXTENSION OF INTERIM ASSISTANCE REIMBURSEMENT

(Section 9210 of House Bill; Section 4118 of Senate Amendment)

Present law

Upon written authorization by an individual, the Secretary of Health and Human Services may withhold SSI benefits due to that individual and pay a State from the benefits withheld an amount sufficient to reimburse the State for interim assistance furnished the individual. This method of reimbursing States for interim SSI assistance may be used only in the case of payments made to an applicant awaiting a determination of initial eligibility.

House bill

(a) The House bill would permit States to also receive reimbursement for interim assistance in cases where they have provided cash assistance to individuals whose SSI benefits were terminated or suspended, but who subsequently were found eligible for benefits.

(b) The House bill would also permit use of this mechanism to reimburse a State for interim assistance given to a recipient whose SSI check has been lost or stolen and not promptly replaced.

Effective date.—The provision would be effective the 13th month following the month of enactment, or if sooner, the first month for which the Secretary determines that it is administratively feasible.

Senate amendment

(a) Same as the House bill.

(b) No provision.

Effective date.—Same as House bill.

Conference agreement

The conference agreement follows the Senate amendment, effective the 13th month following the month of enactment, or, if sooner, the first month for which the Secretary determines that it is administratively feasible. Although the conferees have not agreed to the House provision authorizing use of the interim assistance mechanism with respect to lost or stolen checks, they expect the Social Security Administration to take steps to improve its procedures for responding to the needs of recipients who are facing emergency situations because their checks have been lost or stolen.

J. SPECIAL NOTICE TO BLIND RECIPIENTS

(Section 9211 of House bill; Section 4076 of Senate amendment)

Present law

No provision.

House bill

(a) The House bill would require the Social Security Administration to give blind SSI applicants or recipients the option: (1) to receive a supplementary notice regarding decisions or determinations about their rights under the SSI program, by telephone, within five days after the initial notice is mailed; or (2) to receive the initial notice in the form of a certified letter.

(b) The Secretary would also be required to take appropriate steps, no later than one year after enactment, to ensure that every individual already receiving SSI benefits on the basis of blindness is given an opportunity to make the election provided above.

(c) Finally, the House bill would require the Secretary to study the desirability and feasibility of extending special or supplementary notices to other persons who may lack the ability to read and comprehend regular written notices, and to make any appropriate recommendations within 6 months after enactment.

Effective date.—October 1, 1987.

Senate amendment

(a) The Senate amendment would require the Social Security Administration to give blind SSI applicants or recipients the option: (1) to receive a supplementary notice regarding decisions or determinations relating to their eligibility, by telephone, within five days after the initial notice is mailed; (2) to receive the initial notice in the form of a certified letter; or (3) to receive notification by some alternative procedure established by the Secretary of HHS and agreed to by the individual.

(b) Same as the House bill.

(c) The Senate amendment would require the Secretary to study the desirability and feasibility of extending special or supplementary notices to other persons who may lack the ability to read and comprehend regular written notices, and to make any appropriate recommendations within 12 months after enactment.

Effective date.—The first day of the second calendar quarter to begin after the date of enactment.

Conference agreement

The conference agreement follows the Senate amendment, effective July 1, 1988. The conferees want to clarify that they expect the Social Security Administration to assure that individual recipients are adequately informed that they have the option of selecting whichever method of notification they prefer.

K. CONTINUED SSI BENEFITS FOR RECIPIENTS OF REHABILITATION SERVICES WHOSE BLINDNESS HAS CEASED

(Section 9212 of House bill; Section 4077 of Senate amendment)

Present law

Benefits to a disabled individual may not be terminated, even though the individual's impairment has ceased, if the individual is participating in an approved vocational rehabilitation program and the Commissioner of Social Security determines that the completion or continuation of the program will increase the likelihood

that the individual may be permanently removed from the disability rolls. There is no similar provision with respect to SSI recipients who are blind.

House bill

The House bill would continue SSI benefits to individuals whose blindness has ceased if they are participating in an approved vocational rehabilitation program, under the same conditions as apply to the disabled.

Effective date.—October 1, 1987.

Senate amendment

Same as House bill.

Effective date.—The first day of the second calendar quarter to begin after the date of enactment.

Conference agreement

The conference agreement follows the House bill and the Senate amendment, effective April 1, 1988.

L. SSI ELIGIBILITY FOR INDIVIDUALS IN PUBLIC EMERGENCY SHELTERS

(Section 9213 of House bill; Section 4075 of Senate amendment)

Present law

Individuals in a public institution generally are not eligible for SSI. However, SSI benefits are paid for a period of up to three months out of a 12-month period to an otherwise eligible individual who is living in a public emergency shelter for the homeless.

House bill

The House bill would extend to 12 consecutive months the maximum period during which SSI benefits may be paid to persons in public emergency shelters.

Effective date.—October 1, 1987.

Senate amendment

The Senate amendment would extend to 6 months out of 9 consecutive months the maximum period during which SSI benefits may be paid to persons in public emergency shelters.

Effective date.—The first day of the second calendar quarter beginning after the date of enactment.

Conference agreement

The conference agreement generally follows the Senate amendment in providing that an individual in an emergency public shelter may receive SSI for up to a total of 6 months in any period of 9 consecutive months beginning after December 1987. Thus, an individual may receive up to 6 months of SSI benefits while in a public emergency shelter during the period of January-September 1988, without regard to his status during months prior to January 1988.

M. EXCLUSION OF UNDERPAYMENTS FROM RESOURCES

(Section 9214 of House bill)

Present law

The SSI program disregards retroactive SSI or social security payments as a resource for 6 months.

House bill

The House bill provides that, for the 2-year period beginning January 1, 1987, retroactive SSI and social security payments received during the period must be disregarded as a resource for 12 months.

Effective date.—January 1, 1987.

Senate amendment

No provision.

Conference agreement

The conference agreement generally follows the House bill, but provides that retroactive payments received during the two-year period beginning October 1, 1987 will be disregarded as a resource for 9 months.

N. FULL BENEFITS FOR SSI RECIPIENTS TEMPORARILY IN INSTITUTIONS

(Section 9215 of House bill; Section 4073 of Senate amendment)

Present law

An SSI recipient's benefit is reduced to $25 for any month during all of which he is in a Medicaid institution. Individuals who are in public institutions that are not Medicaid institutions (public mental institutions, for example) are generally not eligible for SSI benefits.

Medicaid regulations give States the option to allow an individual who enters a Medicaid institution to retain, for six months only, more than $25 a month if the State determines that the excess above $25 is needed to maintain a home that he will return to after a temporary stay in the institution.

House bill

The House bill provides full SSI benefits, including State supplementary payments, for a person who enters a public institution or a Medicaid institution, if it is determined that the person's stay is not likely to exceed 3 months and he must continue to maintain a home to which he may return upon leaving the institution.

It would also require the Secretary to establish procedures for making necessary determinations and would authorize him to enter into agreements with State and local public and private agencies for making such determinations. The procedures and agreements would provide appropriate assistance to individuals who, because of their physical or mental condition, have limited ability to furnish the information needed to make the determinations.

Effective date.—July 1, 1988.

Senate amendment

The Senate amendment contains a similar provision. It would require that a physician certify that the individual's stay in the institution is not likely to exceed 3 months. Full benefits could be paid to an individual in a public institution only if the institution's primary purpose is the provision of medical or psychiatric care.

Effective date.—July 1, 1988.

Conference agreement

The conference agreement follows the Senate amendment, effective July 1, 1988.

The conferees recognize that it may frequently be difficult to make the determination that an individual's stay in an institution (or institutions) is likely not to exceed three months. It will require a physician to certify something that is anticipated, not something that has actually happened.

Because of the anticipatory nature of the provision, it is clear that SSI recipients may be able to take advantage of it only if they are informed of its existence. Therefore, the conferees direct the Social Security Administration to include in informational literature for applicants and recipients specific information about their possible eligibility for continuation of full benefits in case of temporary institutionalization. Recipients (or others acting on their behalf) will thus be aware of the need to acquire the necessary certification and to apply for continued full benefits in a timely way.

In developing the procedures to be used in administering this provision the conferees anticipate that the Secretary will examine the procedures used in States like Wisconsin that currently provide for "maintenance of the home" allowances for persons who are in temporary care in Medicaid institutions.

In addition, the conferees note that SSA will have authority under this provision to make arrangements with public or private agencies to assist in making the determinations required under this provision to the extent that it determines this will facilitate the administration of the provision.

Finally, the conferees direct SSA to evaluate the effects of this provision and to report its findings to the Congress within three years after enactment.

O. RETENTION OF MEDICAID FOR CERTAIN WIDOW(ER)S

(Section 9216 of House bill; Section 4078 of Senate amendment)

Present law

SSI law requires individuals to apply for all other benefits for which they may be eligible. Thus, at age 60, disabled widows or widowers who apply for or are receiving SSI, are required to apply for early aged widow or widower social security benefits, which are actuarially reduced. Where the resulting social security benefit is sufficient to end SSI eligibility, the disabled widow or widower may lose Medicaid coverage.

House bill

The House bill would require that an individual who would otherwise qualify for SSI on the basis of disability or blindness, but beginning at age 60 qualifies for social security early aged widow's or widower's benefits and loses eligibility for SSI, nevertheless, be deemed to be an SSI recipient for purposes of Medicaid eligibility. It would continue Medicaid eligibility until the individual becomes eligible for Medicare.

Effective date.—The provision would apply with respect to any individual without regard to whether the determination of his or her eligibility for SSI benefits occurred before, on, or after the date of enactment. However, no individual would be eligible for Medicaid by reason of this amendment before October 1, 1987.

Senate amendment

Same as House bill.

Effective date.—The Senate amendment is the same as the House bill, except that it provides that no individual would be eligible for Medicaid by reason of this amendment before the first day of the second calendar quarter beginning after the date of enactment.

Conference agreement

The conference agreement follows the House bill and the Senate amendment, effective July 1, 1988. The conferees note that the Social Security Administration is not expected to individually identify all of those whose SSI benefits have been terminated in the past. SSA may instead provide a generalized notice to a category or class of Social Security beneficiaries which is likely to include those who may have been affected. The conferees do expect that widows or widowers who lose benefits in the future will receive individual notification of their continued eligibility for Medicaid.

P. DEMONSTRATION TO ASSIST HOMELESS INDIVIDUALS IN OBTAINING SSI

(Section 9217 of House bill; Section 4117 of Senate amendment)

Present law

SSI law requires the Secretary to make payments to eligible individuals who do not have a fixed address but does not authorize specific services and procedures for identifying potentially eligible homeless persons and helping them apply for benefits.

House bill

(a) The House bill would authorize $1.25 million for FY 1988, $2.5 million for FY 1989, and such sums as may be necessary thereafter for projects to demonstrate and test the feasibility of developing and using special procedures to ensure that all homeless individuals in shelters understand their rights to benefits under the SSI program and other programs under the Social Security Act, to provide them with all possible help in applying for benefits and obtaining necessary documentation, and ensuring that they receive the benefits to which they are entitled. It would permit up to 10 States to create SSI outreach team projects at a cost not to exceed $250,000 yearly per project.

(b) A demonstration State's SSI Outreach and Eligibility Team would consist of: a caseworker from the State adult social services agency (or from a local adult social services agency), who would be the team leader, and, if necessary, one other caseworker; a consultative medical examiner who is a physician/psychiatrist qualified to provide consultative examinations for the Disability Determination Service (DDS) of the State; a disability examiner from the State DDS; and a social security claims representative. The Secretary would enter into an agreement with the State providing that team members detailed from their agencies shall retain authority to make decisions and determinations that they would have within the agency.

(c) The team leader would be assigned the following duties: determining, before visiting the shelter, the names of persons there who are potentially eligible for SSI; arranging transportation and, if necessary, accompanying SSI disability applicants to necessary examinations outside the shelter; assisting as needed in interviews; tracking and monitoring decisions made on claims; and assisting as needed in obtaining additional eligibility-related information about applicants.

(d) The Secretary would be required to waive requirements, restrictions, and limits in SSI law or regulations, or in any other law or regulation, that could prevent or hinder the team from carrying out its functions.

Effective date.—October 1, 1987.

Senate amendment

(a) Same as House bill.

(b) No provision.

(c) No provision.

(d) The Secretary would be permitted to waive requirements, restrictions, and limits in SSI law, or in any other law or regulation, that could prevent or hinder operation of the demonstration program.

Effective date.—October 1, 1987.

Conference agreement

The conference agreement authorizes several types of demonstration projects designed to assist homeless individuals who may qualify for SSI. Under this authority, the Secretary of Health and Human Services would be authorized to approve demonstrations which: create cooperative approaches by the Federal, State and local governments; establish, where appropriate, multi-agency SSI outreach teams similar to those proposed in the House bill; test special efforts for identifying homeless individuals who are potentially eligible for SSI; provide assistance to the homeless in applying for benefits and developing evidence related to eligibility; provide special staff training; provide assistance to formerly homeless individuals to ensure their continuing compliance with SSI rules; provide services designed to help homeless individuals obtain permanent housing, nutrition and physical and mental health care; and such other demonstrations as the Secretary may approve.

The conferees do not intend for the Social Security Administration to develop a new disability determination process as a result of

this provision. Instead, the intent is to establish procedures and services, in cooperation with other public and private nonprofit organizations, which reduce the barriers facing homeless individuals eligible for SSI.

Q. SSI ELIGIBILITY REQUIREMENTS FOR CERTAIN ALIENS

(Section 9218 of House bill)

Present law

SSI law requires that the income and resources of an alien's sponsor be considered in determining the alien's eligibility, provided the sponsor signed an affidavit of support. A portion of the sponsor's income (after allowance is made for his own family needs) is deemed available for the alien's support for 3 years after entry into the United States. This provision does not apply to those who become blind or disabled after entry, to refugees, to those granted political asylum, or to aliens sponsored by an agency or organization. AFDC law has a similar provision; however, the AFDC program also restricts the eligibility of aliens sponsored by agencies for 3 years after entry.

House bill

The House bill would make ineligible for SSI for 3 years after entry an alien for whom an organization executed an affidavit of support or similar agreement unless the sponsoring organization has ceased to exist or has been determined by a bankruptcy court to be bankrupt.

Effective date.—Upon enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

R. INCREASE IN PERSONAL NEEDS ALLOWANCE

(Section 4065 of Senate amendment)

Present law

The amount payable to an SSI recipient for any month throughout which he is in a Medicaid institution is reduced to $25 for an individual and to $50 for an individual and spouse. These amounts are intended to cover the cost of personal needs, such as toiletries and other small items, that are not covered by Medicaid. These amounts have been in effect since the SSI program began in 1974.

Medicaid regulations require that States allow SSI recipients who are residents of Medicaid institutions to retain from their income no less than the $25 personal needs allowance benefit standard.

House bill

No provision.

Senate amendment

The Senate amendment would increase the personal needs allowance to $30 for an individual and to $60 for a couple. It would also require States that supplement the Federal benefit to pass through this increase in the Federal payment level to SSI recipients.

Effective date.—July 1, 1988.

Conference agreement

The conference agreement follows the Senate amendment, with an effective date of July 1, 1988.

S. EXCLUSION OF DEATH BENEFITS SPENT ON LAST ILLNESS AND BURIAL

(Section 4072 of Senate amendment)

Present law

SSI law specifies certain kinds of income that must be excluded in determining whether an individual's income is within SSI limits. These include proceeds of a life insurance policy to the extent they are used for purposes of the final illness and burial of the insured person, or $1,500, whichever is less.

House bill

No provision.

Senate amendment

The Senate amendment would exclude payments occasioned by the death of another person, to the extent that the payments do not exceed the amount spent for purposes of the deceased person's last illness and burial. It would also exclude gifts and inheritances to the extent they are used for a last illness or burial.

Effective date.—The first day of the second calendar quarter to begin after the date of enactment.

Conference agreement

The conference agreement follows the Senate amendment, effective April 1, 1988.

V. Social Services, Child Welfare Services, and Other Provisions Relating to Children

A. EXTENSION OF AUTHORITY FOR VOLUNTARY FOSTER CARE PLACEMENTS

(Section 9221 of House bill; Section 4063 of Senate amendment)

Present law

Title IV-E of the Social Security Act authorizes Federal matching for maintenance payments made by States for AFDC-eligible children placed in foster care homes or institutions. Most placements are made under court order. However, since 1981 there has been temporary authority in the law allowing States to make payments for children placed in foster care on a voluntary basis. To use this authority, States must have in place certain foster care protections and procedures. This authority expired September 30, 1987.

House bill

The House bill would permanently extend the authority for Federal matching funds for voluntarily-placed foster care children.

Effective date.—October 1, 1987.

Senate amendment

The Senate amendment is the same as the House bill, except for a technical difference.

Conference agreement

The conference agreement follows the House bill and the Senate amendment, with the technical change in the Senate amendment, effective October 1, 1987.

B. EXTENSION OF AUTHORITY TO TRANSFER FOSTER CARE FUNDS

(Section 9222 of House bill; Section 4062 of Senate amendment)

Present law

In any year that the Federal appropriation for child welfare services exceeds a specified statutory level, there is a mandatory ceiling on the amount each State may receive for foster care maintenance payments. Under this mandatory ceiling, States may, under certain conditions, transfer all unused foster care maintenance funds to their child welfare services program. In any year that the Federal appropriation is below the specified level, States may choose to operate under a voluntary ceiling. Under the voluntary ceiling, States may, under certain conditions, transfer part of their unused foster care maintenance funds to the child welfare services program. The foster care ceilings and transfer authority expired September 30, 1987.

House bill

The House bill would extend the foster care ceilings and transfer authority through September 30, 1989.

Effective date.—October 1, 1987.

Senate amendment

Same as House bill.

Conference agreement

The conference agreement follows the House bill and the Senate amendment, effective October 1, 1987.

C. MOTHER/INFANT FOSTER CARE

(Section 9223 of House bill; Section 4064 of Senate amendment)

Present law

When a minor who is in foster care has a child, the minor continues to be eligible for foster care maintenance payments, but the child is eligible only for regular AFDC benefits, which are generally lower.

House bill

The House bill would require that in cases where a child in foster care is the parent of a son or daughter who is in the same home or institution, the foster care maintenance payments for the child shall include amounts necessary to cover costs of items provided on behalf of the son or daughter.

It would also deem the infants to be title IV-E foster care children for purposes of Medicaid eligibility or for eligibility under the adoption assistance program.

Effective date.—October 1, 1987.

Senate amendment

Same as House bill.

Effective date.—The first day of the second calendar quarter to begin after the date of enactment.

Conference agreement

The conference agreement follows the House bill and the Senate amendment, effective April 1, 1988.

D. INCREASE IN FUNDING FOR TITLE XX BLOCK GRANT

(Section 4061 of Senate amendment)

Present law

The Title XX block grant program provides entitlement funds to the States and certain outlying areas to provide social services aimed at five specified goals. States determine which services to provide in pursuing these goals. Funds are generally allocated on the basis of population. Effective in FY 1984, the ceiling on Title XX entitlement funds was set permanently at $2.7 billion.

House bill

No provision.

Senate amendment

The Senate amendment would increase the Title XX entitlement cap by $50 million to $2.750 billion for fiscal year 1988; the cap reverts to $2.7 billion in 1989.

Effective date.—October 1, 1987.

Conference agreement

The conference agreement follows the Senate amendment with an amendment requiring that the additional funds be used for additional services and not supplant existing State funds.

E. EXTENSION OF TITLE XX AND CHILD WELFARE SERVICES TO AMERICAN SAMOA

(Section 4061 of Senate amendment)

Present law

All States and outlying areas, with the exception of American Samoa, are eligible for Title XX social services funds. In addition,

the law provides Title IV-B funds for child welfare services to States, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam, but not American Samoa.

House bill

No provision.

Senate amendment

The Senate amendment would make American Samoa eligible to participate in both the Title XX and child welfare services programs.

Effective date.—October 1, 1987.

Conference agreement

The conference agreement follows the Senate amendment, effective October 1, 1988.

F. NATIONAL COMMISSION ON CHILDREN

(Section 9703 of House bill; Section 4111 of Senate amendment)

Present law

No provision.

House bill

The House bill would establish a bipartisan National Commission on Children composed of 36 members: 12 persons representing organizations serving children, involved in activities on their behalf, or engaged in academic research about their problems and needs; 12 elected or appointed public officials involved in issues and programs relating to children, and 12 parents or representatives of parents or parents' organizations. It would direct the President, the Speaker of the House, and the President pro tempore of the Senate to each name 12 members, 4 in each category.

The Commission would hold public hearings throughout the country on how to safeguard and enhance the physical, mental, and emotional well-being of children and youth.

The Commission would make recommendations regarding five subjects: health of children, social and support services for children and their parents, education, income security, and tax policy.

The Commission would also seek to identify ways in which public and private organizations and institutions can work together at the community level to identify deficiencies in existing services for families and children and to develop recommendations to ensure that the needs of families and children are met, using all available resources, in a coordinated and comprehensive manner.

The Commission would be required to submit recommendations to the President and Congress by September 30, 1988.

Effective date.—Upon enactment.

Senate amendment

The Senate amendment is the same as the House bill except that it would charge the Commission with making recommendations regarding four subjects: health of children, social and support serv-

ices for children and their parents, education, and income security. Recommendations would be made in the context of the purposes of relevant Federal law.

Effective date.—Upon enactment.

Conference agreement

The conference agreement generally follows the House bill and the Senate amendment. It includes the House provision that directs the Commission to study and make recommendations with respect to tax policy (in addition to health, social and support services, education, and income security), and excludes the Senate provision that directs the Commission to address specified issues within the context of particular provisions of law. The conferees intend that the Commission take into account the work of other commissions and task forces addressing related issues. The Conferees also intend that in selecting members of the Commission, the Speaker of the House will consult with the Committee on Ways and Means, the Committee on Education and Labor and the Committee on Energy and Commerce and the President Pro Tempore of the Senate will consult with the Committee on Finance and the Committee on Labor and Human Resources.

G. BOARDER BABIES DEMONSTRATION PROJECTS

(Section 4112 of Senate amendment)

Present law

No provision.

House bill

No provision.

Senate amendment

The Senate amendment would authorize $4 million yearly for three years to fund demonstration projects to provide residential care for newborn babies whose parents abandon them to the care of hospitals.

Demonstrations could include: (1) projects in which infants remain with a parent in a residential setting, where appropriate care for the infant and suitable treatment for the parent may be assured; (2) projects that assure appropriate individualized care for such infants in a foster home or other nonmedical residential setting; (3) such other projects as the Secretary of Health and Human Services determines will best serve the interests of such infants and will serve as models for projects in other communities.

The Secretary would be required to give priority among applicants for funds to those projects that serve areas most in need of alternative care arrangements for boarder babies, provide for adequate evaluation, and meet such other criteria as he prescribes. Grants could be used to pay costs of maintenance and necessary medical and social services and for such other purposes as the Secretary may allow.

Effective date.—October 1, 1987.

Conference agreement

The conference agreement generally follows the Senate amendment, effective October 1, 1987, with the following modifications: language is added to clarify that infants in non-medical residential settings are to be subject to foster care case planning and case review requirements comparable to those in section 475 of the Social Security Act; the demonstration's purpose is expanded to include projects which are designed to recruit, train, and support foster parents and other professionals working with these infants; and additional application requirements for potential demonstration grantees are established.

The demonstration projects approved by the conferees will provide residential care for newborn babies whose parents abandon them to the care of hospitals. These "boarder babies" are frequently the offspring of drug addicts. They are generally healthy and do not require hospitalization, but cities such as New York have found it difficult to arrange alternative care. The conferees understand that the "boarder baby" problem is likely to grow and become even more intractable in the coming years, and new approaches to resolving this problem, as well as new resources, may well be needed. This will be an issue for future Congressional consideration.

H. STUDY OF CHILDREN WITH AIDS IN FOSTER CARE

(Section 4113 of Senate amendment)

Present law

No provision.

House bill

No provision.

Senate amendment

The Senate amendment would authorize a study to determine the number of infants and children in the United States who have acquired immune deficiency syndrome and who have been placed in foster care; the problems encountered by social services agencies in placing such infants and children; and the potential growth in the number of such children who will require foster care over the next five years. The Secretary of Health and Human Services and the Comptroller General of the General Accounting Office would conduct the study and make recommendations for improving care of AIDS infants and children who lack ongoing parental involvement and support. The Secretary and the Comptroller General could not duplicate activities of the Centers for Disease Control. Recommendations would be made within one year after enactment.

Effective date.—Upon enactment.

Conference agreement

The conference agreement follows the Senate amendment with an amendment requiring that the study be conducted by only one agency, the Department of Health and Human Services.

ing the minimum 500-shareholder requirement in the case of RICs that experience a loss of shareholders through net redemptions of their shares.

The provision is effective for taxable years beginning after December 31, 1986.

B. EMPLOYEE BENEFIT PROVISIONS

1. Limitation on taxable benefit option under cafeteria plan

Present law

Under present law, compensation generally is taxable to employees when actually or constructively received. An amount is constructively received by a taxpayer if it is made available to the taxpayer or the taxpayer has an election to receive such amount.

There are various exceptions to this basic principle of constructive receipt. Under one exception, no amount is included in the income of a participant in a cafeteria plan meeting certain requirements solely because, under the plan, the participant has an election to receive a taxable benefit (sec. 125). Nontaxable benefits that may be available under a cafeteria plan include, for example, health coverage, group-term life insurance, and dependent care assistance. The cafeteria plan exception from the principles of constructive receipt generally also applies for purposes of the Federal Insurance Contribution Act (FICA) and the Federal Unemployment Tax Act (FUTA).

House bill

Under the House bill, the cafeteria plan exception to the constructive receipt principle is limited to $500. Thus, for example, if an employee is eligible under a cafeteria plan to reduce her salary by $1,500 to buy health coverage or to take the $1,500 in taxable benefits, the employee is in constructive receipt of $1,000 under the bill, which is the excess of the taxable benefits available over $500. This would apply even if she elected to acquire $1,500 of health coverage under the cafeteria plan. Of course, if the employee in this example elected to receive $1,500 in cash, such employee would only include this $1,500 once; i.e., the employee would not include the $1,000 constructively received and include an additional $1,500 actually received.

The $500 limit applies on an individual basis, rather than a plan basis, so that, for purposes of the limit, all cafeteria plans of all employers in which an individual participates are aggregated. Correspondingly, the limit applies to the individual's taxable year. In addition, the employer is required to report on its employees' Forms W–2 the amount of taxable benefits available but not chosen by any employee.

The $500 limit on the cash option applies under the bill for FICA and FUTA purposes.

This provision applies to taxable years beginning after December 31, 1987.

Senate amendment

No provision.

penditures were likely to result in revocation of the organization's tax-exempt status, unless the manager's agreement was not willful and was due to reasonable cause. The burden of proof as to whether the manager knowingly participated in the lobbying expenditures is on the Internal Revenue Service. The fact that the excise tax is imposed on an organization does not itself establish that any manager of the organization is subject to the excise tax.

The reasonable cause exception to the tax applicable to managers is to be applied in the same manner as the present-law reasonable cause exception to the excise tax liability of managers of a private foundation under section 4945 (see Treas. Reg. sec. 53.4945–1). Thus, a manager is liable for the excise tax under the conference agreement only if the IRS shows that, in agreeing to the making of the lobbying expenditures, the manager knew that such expenditures constituted lobbying expenditures and knew that as a result of such expenditures the organization was likely to lose its tax-exempt status under section 501(c)(3), and only if the manager failed to obtain an opinion of counsel concerning the expenditures that would protect the manager under the reasonable cause exception.

APPENDIX—ESTIMATED BUDGET EFFECTS OF REVENUE PROVISIONS OF CONFERENCE AGREEMENT—FISCAL YEARS 1988–90

[Millions of dollars]

Item	1988	1989	1990	1988–90
PART 1.—REVENUE PROVISIONS				
I. Individual Tax Provisions:				
A. Income Tax Provisions:				
1. Child and dependent care credit: Deny credit for overnight camp expenses	11	106	112	229
2. Limit interest deduction: Home equity debt in excess of acquisition debt capped at $100,000; total for qualified residence debt capped at $1 million	8	31	54	93
3. One-year delay in application of 2% floor to indirect deductions through regulated investment companies	−239			−239
B. Employee Benefit Provisions: Modify definition of active participant for IRA rules	(1)	(1)	(1)	(1)
II. Business Tax Provisions:				
A. Accounting Provisions:				
1. Repeal vacation pay reserve	614	885	1,639	3,138
2. Repeal completed contract method	417	773	975	2,165
3. Require capitalization of pension past service liability	91	153	173	417
4, Repeal installment method for dealers	1,593	2,750	1,942	6,285
5. Repeal cash method of accounting for farms with receipts over $25 million	27	42	45	114
6. Changes in required taxable years for partnerships, S corporations, and personal service corporations	31	(1)	3	34
B. Partnership Provisions:				
1. Portfolio income	77	127	170	374
2. Other publicly-traded partnership provisions	22	42	60	124
3. Treatment of tax-exempt partners	28	97	111	236
4. Study of publicly-traded partnerships				
C. Corporate Provisions:				
1. Modify computation of earnings and profits for intercorporate dividends and basis adjustments (overrule Woods Investment Company case)	34	208	450	692
2. Denial of graduated rates for personal service corporations	75	125	140	340
3. Dividend received deduction to 70%	219	381	426	1,026

APPENDIX—ESTIMATED BUDGET EFFECTS OF REVENUE PROVISIONS OF CONFERENCE AGREEMENT—FISCAL YEARS 1988–90—Continued

[Millions of dollars]

Item	1988	1989	1990	1988–90
4. Reduction of tax avoidance in certain corporate dispositions	37	94	273	404
5. Greenmail and hostile corporate takeovers	(1)	(1)	(1)	(1)
6. Limitations on net operating loss carryforwards of corporations following worthless securities deduction by shareholders	5	8	9	22
7. Tax loss mergers and benefit acquisitions	26	44	48	118
8. LIFO recapture on conversion from C corporation to S corporation	58	129	185	372
9. Regulated Investment Companies capital gains distribution	240	12	15	267
D. Pensions: Modify funding rules [2]	679	1,502	992	3,173
E. Foreign Tax Provisions: Treatment of South African income	20	23	14	57
F. Insurance Provisions:				
1. Interest rate used in computing reserves for life insurance and annuity contracts	43	154	208	405
2. Treatment of investment income of foreign insurance companies	11	27	39	77
3. Minimum tax treatment of mutual life insurance companies	25	57	61	143
III. Estimated Tax Provisions	806	117	79	1,002
IV. Estate and Gift Taxes:				
1. Freeze estate and gift rates at 55%	21	176	232	429
2. Modify rates and unified credit	2	23	31	56
3. Valuation of property (estate tax freezes & minority discount)	6	46	57	109
4. ESOP estate tax deduction	1,226	1,553	1,862	4,641
V. Excise Taxes:				
1. Telephone tax: 3-year extension	1,324	2,266	2,472	6,062
2. Collect diesel fuel and special motor fuels taxes on sales to retailer	215	230	200	645
3. Extension of termination date for coal excise tax rate				
VI. Other Revenue—Increase Provisions:				
A. Targeted Jobs Tax Credit	4	2	2	7
B. Illegal Federal Irrigation Subsidies as Gross Income	(1)	(1)	(1)	1
C. Compliance Provisions:				
1. Escheat of refunds	10	10	10	30
2. IRS funding				
D. Tax-Exempt Bond Provisions:				
1. Limitation on issuance of tax-exempt bonds to acquire existing output facilities	9	70	162	241
2. Limitation on issuance of tax-exempt bonds by Indian tribes	6	18	29	53
VII. Employment Taxes (Title IX):				
1. Railroad retirement taxes	144	182	183	509
2. FUTA tax: 3-year extension	715	1,009	1,033	2,757
3. FICA taxes:				
a. Expand employer share of FICA tax to include all cash tips	184	281	302	767
b. Expand FICA tax to inactive duty reservists, certain agricultural employees, family members, and group-term life insurance includible in wages	187	255	275	717
VIII. Vaccine Compensation Tax and Trust Fund (Title IX) [3]	67	89	−5	151
Subtotal: Part 1.—Revenue Provisions	9,078	14,097	15,068	38,243
PART 2.—USER FEES (Title IX)				
I. Internal Revenue Service	46	60	60	166
II. Extensions and increases in certain Alcohol, Tobacco, and Firearms occupational taxes	167	106	106	379
III. Customs Service	122	152	591	865
Subtotal: Part 2.—User Fees	335	318	757	1,410
Grand Total	9,413	14,415	15,825	39,653

[1] Gain of less than $500,000.
[2] Estimates represent the net effects of full-funding rules and underfunding rules.
[3] Estimate net of outlay amounts.

From the Committee on the Budget, for consideration of the House bill (except Title X), and the Senate amendment (except subtitle B of Title IV), and modifications committed to conference:

WILLIAM H. GRAY III,
BUTLER DERRICK,
MARTIN FROST,
ED JENKINS,
PAT WILLIAMS,
JAMES L. OBERSTAR,
WILLIAM F. GOODLING,

From the Committee on the Budget, for consideration of Title X of the House bill, and subtitle B of Title IV of the Senate amendment, and modifications committed to conference:

ED JENKINS,

From the Committee on Agriculture, for consideration of Title I and section 5003 of the House bill, and Title VIII and sections 2101 through 2113, 2301, 3001, and 9005 of the Senate amendment, and modifications committed to conference:

DE LA GARZA,
ED JONES,
CHARLIE ROSE,
JERRY HUCKABY,
DAN GLICKMAN,
CHARLIE STENHOLM,
LEON E. PANETTA,
ED MADIGAN,
ARLAN STANGELAND,
ROBERT F. SMITH,
TOM LEWIS,
WALLY HERGER,

From the Committee on Armed Services, for consideration of section 5001 of the Senate amendment, and modifications committed to conference:

LES ASPIN,
BEVERLY BYRON,
WILLIAM L. DICKINSON,

From the Committee on Banking, Finance and Urban Affairs, for consideration of Title II of the House bill, and sections 9006, 9007, 9010, and 9012 of the Senate amendment, and modifications committed to conference:

HENRY GONZALEZ,
FRANK ANNUNZIO,
MARY ROSE OAKAR,
ROBERT GARCIA,

From the Committee on Banking, Finance, and Urban Affairs, for consideration of Title X of the Senate amendment, and modifications committed to conference:

FERNAND ST GERMAIN,
MARY ROSE OAKAR,

From the Committee on Education and Labor, for consideration of Title III and subtitle E and section 9602 of Title IX of the House bill, and Part VI of Title IV, Title VI, and sections 4111, 4112, and 9008 of the Senate amendment, and modifications committed to conference:

AUGUSTUS F. HAWKINS,
(except for the pension provisions)
WILLIAM D. FORD,
(except for the pension provisions)
JOSEPH M. GAYDOS,
(except for the pension provisions)
WILLIAM L. CLAY,
(except for the pension provisions)
PAT WILLIAMS,
(except for the pension provisions)
DALE E. KILDEE,
(except for the pension provisions)
MAJOR R. OWENS,
(except for the pension provisions)
JAMES M. JEFFORDS,
WILLIAM F. GOODLING,
TOM COLEMAN,
MARGE ROUKEMA,

From the Committee on the Budget, for consideration of Title III and subtitle E of Title IX of the House bill, and part VI of subtitle B of title IV and subtitle A of Title VI of the Senate amendment:

DELBERT LATTA,
CONNIE MACK,
DENNY SMITH,

From the Committee on Energy and Commerce, for consideration of subtitles A, B, and C of Title IV, parts 2 through 4 of subtitle C of Title IX, and sections 1052 and 9602 of the House bill, and subparts II through V of part A, subparts I (except sections 4086 and 4091) and II of part B of subtitle A of Title IV and sections 4001(q), 4002(b), 4002(c), 4051, 4111 through 4113, 9010, and 9011 of the Senate amendment, and modifications committed to conference:

JOHN D. DINGELL,
HENRY A. WAXMAN,
JAMES H. SCHEUER,
CARDISS COLLINS,
MIKE SYNAR,
RON WYDLER,
JIM SLATTERY,
BOB WHITTAKER,
(only for the Medicaid provisions)
TOM TAUKE,
(only for the Medicaid provisions)

From the Committee on Energy and Commerce, for consideration of sections 4301, 5001, and 6201 of the House bill, and subtitle A of Title II and Title III (except sections 3001 and 3003) of the Senate amendment, and modifications committed to conference:

JOHN D. DINGELL,
PHILIP R. SHARP,
AL SWIFT,
MICKEY LELAND,
JIM COOPER,
JIM SLATTERY,
NORMAN F. LENT,
CARLOS MOORHEAD,
BILL DANNEMEYER,
(only for section 6201 of the House bill)
JACK FIELDS,

From the Committee on Energy and Commerce, for consideration of section 9033 of the House bill, and section 4583 of the Senate amendment, and modifications committed to conference:

JOHN D. DINGELL,
TOM LUKEN,
JAMES J. FLORIO,
BILLY TAUZIN,
JERRY SIKORSKI,
RICK BOUCHER,
JIM SLATTERY,
NORMAN F. LENT,
BOB WHITTAKER,
TOM TAUKE,
MIKE BILIRAKIS,

From the Committee on Interior and Insular Affairs, for consideration of sections 4301 and 5001 of the House bill, and sections 2001 through 2009 and 3010 of the Senate amendment, and modifications committed to conference:

MO UDALL,
GEO MILLER,
AUSTIN J. MURPHY,
BRUCE F. VENTO,
ED MARKEY,
(only for purposes of NRC user fees)
NICK RAHALL,
(only for purposes of NRC user fees)
DON YOUNG,
MANUEL LUJAN, Jr.,
ROBERT J. LAGOMARSINO,
RON MARLENEE,

From the Committee on Interior and Insular Affairs, for consideration of sections 5002 through 5004 of the House bill, and sections 2101 through 2113 and 9009 of the Senate amendment, and modifications committed to conference:

MO UDALL,
GEORGE MILLER,
PHILIP R. SHARP,
ED MARKEY,
AUSTIN J. MURPHY,
NICK RAHALL,
DON YOUNG,
MANUEL LUJAN, Jr.,
ROBERT J. LAGOMARSINO,
RON MARLENEE,

From the Committee on Interior and Insular Affairs, for consideration of section 5005 of the House bill, and sections 2201 through 2203 and 2301 of the Senate amendment, and modifications committed to conference:

MO UDALL,
GEO MILLER,
PHILIP R. SHARP,
ED MARKEY,
SAM GEJDENSON,
BRUCE F. VENTO,
DON YOUNG,
MANUEL LUJAN, Jr.,
ROBERT J. LAGOMARSINO,
RON MARLENEE,

From the Committee on the Judiciary, for consideration of the bankruptcy provisions contained in sections 9432 and 9433 of the House bill, and sections 4553(e), 4558, and 4559 of the Senate amendment, and modifications committed to conference:

HAMILTON FISH, Jr.,
BILL DANNEMEYER,
CARLOS J. MOORHEAD,
HENRY J. HYDE,

From the Committee on Merchant Marine and Fisheries, for consideration of Title VI of the House bill, and sections

1002, 2002 (insofar as that section would add a new section 409 (c) and (d) to the Nuclear Waste Policy Act of 1982), 2008, and 3001 of the Senate amendment, and modifications committed to conference:

WALTER B. JONES,
GERRY E. STUDDS,
MIKE LOWRY,
EARL HUTTO,
BOB DAVIS,
DON YOUNG,
(except for sections 2002 and 2008 of the Senate amendment)
NORMAN F. LENT,
(except for sections 2002, 2008, and 3001 of the Senate amendment)
NORMAN D. SHUMWAY,
BILL HUGHES,
(solely for section 3001 of the Senate amendment)

From the Committee on Post Office and Civil Service, for consideration of Title VII of the House bill, and Title V (except section 5002) of the Senate amendment, and modifications committed to conference:

WILLIAM D. FORD,
MICKEY LELAND,
GARY L. ACKERMAN,
GENE TAYLOR,
FRANK HORTON,

From the Committee on Public Works and Transportation only for consideration of subtitle A of Title VI of the House bill:

JAMES J. HOWARD,
ROBERT A. ROE,
NORMAN Y. MINETA,
JAMES L. OBERSTAR,
HENRY NOWAK,
NICK RAHALL,
JOHN PAUL HAMMERSCHMIDT,
BUD SHUSTER,
ARLAN STANGELAND,
NEWT GINGRICH,

From the Committee on Government Operations, for consideration of sections 5002 and 9003 of the Senate amendment, and modifications committed to conference:

JACK BROOKS,
JOHN CONYERS,
CARDISS COLLINS,
GLENN ENGLISH,
HENRY A. WAXMAN,
TED WEISS,
FRANK HORTON,
ROBERT A. WALKER,
WILLIAM F. CLINGER,
AL MCCANDLESS.

From the Committee on Science, Space, and Technology, for consideration of sections 2002 (insofar as that section would add new sections 403(i) and 410 to the Nuclear Waste Policy Act of 1982), 2006, and 2008 of the Senate amendment, and modifications committed to conference:

ROBERT A. ROE,
GEORGE E. BROWN, Jr.,
JAMES H. SCHEUER,
TIM VALENTINE,
JIM CHAPMAN,
SID MORRISON,
LAMAR SMITH,
ERNEST KONNYU,

From the Committee on Veterans' Affairs, for consideration of Title VIII of the House bill, and Title VII of the Senate amendment, and modifications committed to conference:

G.V. MONTGOMERY,
MARCY KAPTUR,
GERALD B.H. SOLOMON,

From the Committee on Ways and Means, for consideration of Title III, subtitle A of Title IV, and Title IX of the House bill, and subtitle A of Title IV (except subpart V of Part A and Subpart II of Part B) and subtitle A of Title VI and section 8309 of the Senate amendment, and modifications committed to conference:

DAN ROSTENKOWSKI,
SAM M. GIBBONS,
J.J. PICKLE,
CHARLES B. RANGEL,
PETE STARK,
ANDREW JACOBS, Jr.,
THOMAS J. DOWNEY,
BILL GRADISON,
BILL FRENZEL,
(only for the pension provisions)
RICHARD T. SCHULZE,
(only for the pension provisions)

From the Committee on Ways and Means, for consideration of Title X of the House bill, and subtitle B of Title IV of the Senate amendment, and modifications committed to conference:

DAN ROSTENKOWSKI,
SAM M. GIBBONS,
J.J. PICKLE,
CHARLES B. RANGEL,
PETE STARK,
ANDREW JACOBS, Jr.,
THOMAS J. DOWNEY,

From the Committee on Ways and Means, for consideration of Title X of the Senate amendment, and modifications committed to conference:

DAN ROSTENKOWSKI,
THOMAS J. DOWNEY,
JOHN J. DUNCAN,

As additional conferees, for consideration of the House bill (except Title X), and the Senate amendment (except subtitle B of Title IV), and modifications committed to conference:

THOMAS S. FOLEY,
DICK CHENEY,
Managers on the Part of the House.

From the Committee on the Budget:

LAWTON CHILES,
ERNEST F. HOLLINGS,
J. BENNETT JOHNSTON,
JIM SASSER,
DON RIEGLE,
J.J. EXON,
FRANK R. LAUTENBERG,
PETE V. DOMENICI,
RUDY BOSCHWITZ,
BOB DOLE,

From the Committee on Agriculture, Nutrition, and Forestry:

PAT LEAHY,
JOHN MELCHER,
DAVID PRYOR,
RICHARD G. LUGAR,
THAD COCHRAN,

From the Committee on Armed Services:

SAM NUNN,
JOHN GLENN,

From the Committee on Banking, Housing, and Urban Affairs:

WILLIAM PROXMIRE,
ALAN CRANSTON,
PAUL SARBANES,

From the Committee on Commerce, Science, and Transportation:

FRITZ HOLLINGS,
DANIEL K. INOUYE,
WENDELL H. FORD,
JACK DANFORTH,

From the Committee on Energy and Natural Resources:

J. BENNETT JOHNSTON,
DALE BUMPERS,
WENDELL FORD,
JOHN MELCHER,
JEFF BINGAMAN,
TIM WIRTH,
DON NICKLES,

From the Committee on Environment and Public Works;
QUENTIN N. BURDICK,
GEORGE MITCHELL,
MAX BAUCUS,
JOHN BREAUX,
ROBERT T. STAFFORD,
JOHN H. CHAFEE,
DAVE DURENBERGER,
From the Committee on Finance:
LLOYD BENTSEN,
SPARK M. MATSUNAGA,
DANIEL PATRICK MOYNIHAN,
MAX BAUCUS,
DAVID L. BOREN,
BILL BRADLEY,
GEORGE MITCHELL,
BOB PACKWOOD,
JOHN C. DANFORTH,
JOHN H. CHAFEE,
JOHN HEINZ,
From the Committee on Governmental Affairs:
JOHN GLENN,
LAWTON CHILES,
JIM SASSER,
DAVID PRYOR,
TED STEVENS,
(except I do not concur with the budget reduction allocations pursuant to the Summit agreement)
WARREN B. RUDMAN,
From the Committee on Labor and Human Resources:
TED KENNEDY,
CLAIBORNE PELL,
PAUL SIMON,
ORRIN HATCH,
ROBERT T. STAFFORD,
DAN QUAYLE,
From the Committee on Veterans' Affairs:
ALAN CRANSTON,
SPARK M. MATSUNAGA,
FRANK H. MURKOWSKI,
Managers on the Part of the Senate.

○

Finder's Aid

P.L. 100-300 (102 Stat. 437) Approved April 29, 1988
"International Child Abduction Remedies Act"

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep. 100-525
Agreement for Use of Parent Locator Service in Determining Whereabouts of Parent or Child	463(b)	11(1)	441	4, 18
Agreement for Use of Parent Locator Service in Determining Whereabouts of Parent or Child	463(c)	11(2)	442	4, 19
Agreement for Use of Parent Locator Service in Determining Whereabouts of Parent or Child	463(e) New	11(3)	442	5, 7, 9-10, 15, 19, 23

Public Law 100-300
100th Congress

An Act

To establish procedures to implement the Convention on the Civil Aspects of International Child Abduction, done at The Hague on October 25, 1980, and for other purposes.

Apr. 29, 1988
[H.R. 3971]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

International Child Abduction Remedies Act.
42 USC 11601 note.

SECTION 1. SHORT TITLE.

This Act may be cited as the "International Child Abduction Remedies Act".

SEC. 2. FINDINGS AND DECLARATIONS.

42 USC 11601.

(a) FINDINGS.—The Congress makes the following findings:

(1) The international abduction or wrongful retention of children is harmful to their well-being.

(2) Persons should not be permitted to obtain custody of children by virtue of their wrongful removal or retention.

(3) International abductions and retentions of children are increasing, and only concerted cooperation pursuant to an international agreement can effectively combat this problem.

(4) The Convention on the Civil Aspects of International Child Abduction, done at The Hague on October 25, 1980, establishes legal rights and procedures for the prompt return of children who have been wrongfully removed or retained, as well as for securing the exercise of visitation rights. Children who are wrongfully removed or retained within the meaning of the Convention are to be promptly returned unless one of the narrow exceptions set forth in the Convention applies. The Convention provides a sound treaty framework to help resolve the problem of international abduction and retention of children and will deter such wrongful removals and retentions.

(b) DECLARATIONS.—The Congress makes the following declarations:

(1) It is the purpose of this Act to establish procedures for the implementation of the Convention in the United States.

(2) The provisions of this Act are in addition to and not in lieu of the provisions of the Convention.

(3) In enacting this Act the Congress recognizes—

(A) the international character of the Convention; and

(B) the need for uniform international interpretation of the Convention.

(4) The Convention and this Act empower courts in the United States to determine only rights under the Convention and not the merits of any underlying child custody claims.

SEC. 3. DEFINITIONS.

42 USC 11602.

For the purposes of this Act—

(1) the term "applicant" means any person who, pursuant to the Convention, files an application with the United States

Authority under subsection (a), the head of such department, agency, or instrumentality shall promptly cause a search to be made of the files and records maintained by such department, agency, or instrumentality in order to determine whether the information requested is contained in any such files or records. If such search discloses the information requested, the head of such department, agency, or instrumentality shall immediately transmit such information to the United States Central Authority, except that any such information the disclosure of which—

Classified information.

(1) would adversely affect the national security interests of the United States or the law enforcement interests of the United States or of any State; or

(2) would be prohibited by section 9 of title 13, United States Code;

Defense and national security. Law enforcement and crime.

shall not be transmitted to the Central Authority. The head of such department, agency, or instrumentality shall, immediately upon completion of the requested search, notify the Central Authority of the results of the search, and whether an exception set forth in paragraph (1) or (2) applies. In the event that the United States Central Authority receives information and the appropriate Federal or State department, agency, or instrumentality thereafter notifies the Central Authority that an exception set forth in paragraph (1) or (2) applies to that information, the Central Authority may not disclose that information under subsection (a).

(d) INFORMATION AVAILABLE FROM PARENT LOCATOR SERVICE.—To the extent that information which the United States Central Authority is authorized to obtain under the provisions of subsection (c) can be obtained through the Parent Locator Service, the United States Central Authority shall first seek to obtain such information from the Parent Locator Service, before requesting such information directly under the provisions of subsection (c) of this section.

(e) RECORDKEEPING.—The United States Central Authority shall maintain appropriate records concerning its activities and the disposition of cases brought to its attention.

SEC. 10. INTERAGENCY COORDINATING GROUP.

42 USC 11609.

The Secretary of State, the Secretary of Health and Human Services, and the Attorney General shall designate Federal employees and may, from time to time, designate private citizens to serve on an interagency coordinating group to monitor the operation of the Convention and to provide advice on its implementation to the United States Central Authority and other Federal agencies. This group shall meet from time to time at the request of the United States Central Authority. The agency in which the United States Central Authority is located is authorized to reimburse such private citizens for travel and other expenses incurred in participating at meetings of the interagency coordinating group at rates not to exceed those authorized under subchapter I of chapter 57 of title 5, United States Code, for employees of agencies.

Government organization and employees.

SEC. 11. AGREEMENT FOR USE OF PARENT LOCATOR SERVICE IN DETERMINING WHEREABOUTS OF PARENT OR CHILD.

Section 463 of the Social Security Act (42 U.S.C. 663) is amended—

(1) by striking "under this section" in subsection (b) and inserting "under subsection (a)";

(2) by striking "under this section" where it first appears in subsection (c) and inserting "under subsection (a), (b), or (e)"; and

(3) by adding at the end the following new subsection:

Contracts.

"(e) The Secretary shall enter into an agreement with the Central Authority designated by the President in accordance with section 7 of the International Child Abduction Remedies Act, under which the services of the Parent Locator Service established under section 453 shall be made available to such Central Authority upon its request for the purpose of locating any parent or child on behalf of an applicant to such Central Authority within the meaning of section 3(1) of that Act. The Parent Locator Service shall charge no fees for services requested pursuant to this subsection.".

42 USC 11610.

SEC. 12. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated for each fiscal year such sums as may be necessary to carry out the purposes of the Convention and this Act.

Approved April 29, 1988.

LEGISLATIVE HISTORY—H.R. 3971:

HOUSE REPORTS: No. 100-525 (Comm. on the Judiciary).
CONGRESSIONAL RECORD, Vol. 134 (1988):
Mar. 28, considered and passed House.
Apr. 12, considered and passed Senate, amended.
Apr. 25, House concurred in Senate amendment.

○

100TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPORT
100-525

INTERNATIONAL CHILD ABDUCTION REMEDIES ACT

MARCH 23, 1988.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. FRANK, from the Committee on the Judiciary, submitted the following

REPORT

[To accompany H.R. 3971]

[Including cost estimate of the Congressional Budget Office]

The Committee on the Judiciary, to whom was referred the bill (H.R. 3971) to establish procedures to implement the 1980 Hague Convention on the Civil Aspects of International Child Abduction, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike out all after the enacting clause and insert in lieu therof the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "International Child Abduction Remedies Act".

SEC. 2. FINDINGS AND DECLARATIONS.

(a) FINDINGS.—The Congress makes the following findings:

(1) The international abduction or wrongful retention of children is harmful to their well-being.

(2) Persons should not be permitted to obtain custody of children by virtue of their wrongful removal or retention.

(3) International abductions and retentions of children are increasing, and only concerted cooperation pursuant to an international agreement can effectively combat this problem.

(4) The Convention on the Civil Aspects of International Child Abduction, done at The Hague on October 25, 1980, establishes legal rights and procedures for the prompt return of children who have been wrongfully removed or retained, as well as for securing the exercise of visitation rights. Children who are wrongfully removed or retained within the meaning of the Convention are to be promptly returned unless one of the narrow exceptions set forth in the Convention applies. The Convention provides a sound treaty framework to help resolve the problem of international abduction and retention of children and will deter such wrongful removals and retentions.

(b) DECLARATIONS.—The Congress makes the following declarations:

(1) It is the purpose of this Act to establish procedures for the implementation of the Convention in the United States.

(2) The provisions of this Act are in addition to and not in lieu of the provisions of the Convention.

(3) In enacting this Act the Congress recognizes—

(A) the international character of the Convention; and

(B) the need for uniform international interpretation of the Convention.

(4) The Convention and this Act empower courts in the United States to determine only rights under the Convention and not the merits of any underlying child custody claims.

SEC. 3. DEFINITIONS.

For the purposes of this Act—

(1) the term "applicant" means any person who, pursuant to the Convention, files an application with the United States Central Authority or a Central Authority of any other party to the Convention for the return of a child alleged to have been wrongfully removed or retained or for arrangements for organizing or securing the effective exercise of rights of access pursuant to the Convention;

(2) the term "Convention" means the Convention on the Civil Aspects of International Child Abduction, done at The Hague on October 25, 1980;

(3) the term "Parent Locator Service" means the service established by the Secretary of Health and Human Services under section 453 of the Social Security Act (42 U.S.C. 653);

(4) the term "petitioner" means any person who, in accordance with this Act, files a petition in court seeking relief under the Convention;

(5) the term "person" includes any individual, institution, or other legal entity or body;

(6) the term "respondent" means any person against whose interests a petition is filed in court, in accordance with this Act, which seeks relief under the Convention; and

(7) the term "rights of access" means visitation rights;

(8) the term "State" means any of the several States, the District of Columbia, and any commonwealth, territory, or possession of the United States; and

(9) the term "United States Central Authority" means the agency of the Federal Government designated by the President under section 7(a).

SEC. 4. JUDICIAL REMEDIES.

(a) JURISDICTION OF THE COURTS.—(1) The courts of the States shall have original jurisdiction of all actions arising under the Convention.

(2) The United States district courts shall have jurisdiction of any action arising under the Convention to the extent authorized by chapter 85 of title 28, United States Code.

(b) PETITIONS.—Any person seeking to initiate judicial proceedings under the Convention for the return of a child or for arrangements for organizing or securing the effective exercise of rights of access to a child may do so by commencing a civil action by filing a petition for the relief sought in any court which has jurisdiction of such action and which is authorized to exercise its jurisdiction in the place where the child is located at the time the petition is filed.

(c) NOTICE.—Notice of an action brought under subsection (b) shall be given in accordance with the applicable law governing notice in interstate child custody proceedings.

(d) DETERMINATION OF CASE.—The court in which an action is brought under subsection (b) shall decide the case in accordance with the Convention.

(e) BURDENS OF PROOF.—A petitioner in an action brought under subsection (b) shall establish by a preponderance of the evidence—

(1) in the case of an action for the return of a child, that the child has been wrongfully removed or retained within the meaning of the Convention; and

(2) in the case of an action for arrangements for organizing or securing the effective exercise of rights of access, that the petitioner has such rights.

In the case of an action for the return of a child, a respondent who opposes the return of the child has the burden of establishing by clear and convincing evidence that one of the exceptions set forth in article 12, 13, or 20 of the Convention applies.

(f) APPLICATION OF THE CONVENTION.—For purposes of any action brought under this Act—

(1) the term "authorities", as used in article 15 of the Convention to refer to the authorities of the state of the habitual residence of a child, includes courts and appropriate government agencies;

(2) the terms "wrongful removal or retention" and "wrongfully removed or retained", as used in the Convention, include a removal or retention of a child before the entry of a custody order regarding that child; and

(3) the term "commencement of proceedings", as used in article 12 of the Convention, means, with respect to the return of a child located in the United States, the filing of a petition in accordance with subsection (b) of this section.

(g) FULL FAITH AND CREDIT.—Full faith and credit shall be accorded by the courts of the States and the courts of the United States to the judgment of any other such court ordering or denying the return of a child, pursuant to the Convention, in an action brought under this Act.

(h) REMEDIES UNDER THE CONVENTION NOT EXCLUSIVE.—The remedies established by the Convention and this Act shall be in addition to remedies available under other laws or international agreements.

SEC. 5. PROVISIONAL REMEDIES.

(a) AUTHORITY OF COURTS.—In furtherance of the objectives of article 7(b) and other provisions of the Convention, and subject to the provisions of subsection (b) of this section, any court exercising jurisdiction of an action brought under section 4(b) of this Act may take or cause to be taken measures under Federal or State law, as appropriated, to protect the well-being of the child involved or to prevent the child's further removal or concealment before the final disposition of the petition.

(b) LIMITATION ON AUTHORITY.—No court exercising jurisdiction of an action brought under section 4(b) may, under section (a) of this section, order a child removed from a person having physical control of the child unless the applicable requirements of State law are satisfied.

SEC. 6. ADMISSIBILITY OF DOCUMENTS.

With respect to any application to the United States Central Authority, or any petition to a court under section 4, which seeks relief under the Convention, or any other documents or information included with such application or petition or provided after such submission which relates to the application or petition, as the case may be, no authentication of such application, petition, document, or information shall be required in order for the application, petition, document, or information to be admissible in court.

SEC. 7. UNITED STATES CENTRAL AUTHORITY.

(a) DESIGNATION.—The President shall designate a Federal agency to serve as the Central Authority for the United States under the Convention.

(b) FUNCTIONS.—The functions of the United States Central Authority are those ascribed to the Central Authority by the Convention and this Act.

(c) REGULATORY.—The United States Central Authority is authorized to issue such regulations as may be necessary to carry out its functions under the Convention and this Act.

(d) OBTAINING INFORMATION FROM PARENT LOCATOR SERVICE.—The United States Central Authority may, to the extent authorized by the Social Security Act, obtain information form the Parent Locator Service.

SEC. 8. COSTS AND FEES.

(a) ADMINISTRATIVE COSTS.—No department, agency, or instrumentality of the Federal Government or of any State or local government may impose on an applicant any fee in relation to the administrative processing of applications submitted under the Convention.

(b) COSTS INCURRED IN CIVIL ACTIONS.—(1) Petitioners may be required to bear the costs of legal counsel or advisors, court costs incurred in connection with their petitions, and travel costs for the return of the child involved and any accompanying persons, except as provided in paragraphs (2) and (3).

(2) Subject to paragraph (3), legal fees or court costs incurred in connection with an action brought under section 4 shall be borne by the petitioner unless they are covered by payments from Federal, State, or local legal assistance or other programs.

(3) Any court ordering the return of a child pursuant to an action brought under section 4 shall order the respondent to pay necessary expenses incurred by or on behalf of the petitioner, including court costs, legal fees, foster home or other care during the course of proceedings in the action, and transportation costs related to the return of the child, unless the respondent establishes that such order would be clearly inappropriate.

SEC. 9. COLLECTION, MAINTENANCE, AND DISSEMINATION OF INFORMATION.

(a) IN GENERAL.—In performing its functions under the Convention, the United States Central Authority may, under such conditions as the Central Authority prescribes by regulation, but subject to subsection (c), receive from or transmit to any department, agency, or instrumentality of the Federal Government or of any State or foreign government, and receive from or transmit to any applicant, petitioner, or respondent, information necessary to locate a child or for the purpose of otherwise implementing the Convention with respect to a child, except that the United States Central Authority—

(1) may receive such information from a Federal or State department, agency, or instrumentality only pursuant to applicable Federal and State statutes; and

(2) may transmit any information received under this subsection notwithstanding any provision of law other than this Act.

(b) REQUESTS FOR INFORMATION.—Requests for information under this section shall be submitted in such manner and form as the United States Central Authority may prescribe by regulation and shall be accompanied or supported by such documents as the United States Central Authority may require.

(c) RESPONSIBILITY OF GOVERNMENT ENTITIES.—Whenever any department, agency, or instrumentality of the United States or of any State receives a request from the United States Central Authority for information authorized to be provided to such Central Authority under subsection (a), the head of such department, agency, or instrumentality shall promptly cause a search to be made of the files and records maintained by such department, agency, or instrumentality in order to determine whether the information requested is contained in any such files or records. If such search discloses the information requested, the head of such department, agency, or instrumentality shall immediately transmit such information to the United States Central Authority, except that any such information the disclosure of which—

(1) would adversely affect the national security interests of the United States or the law enforcement interests of the United States or of any State; or

(2) would be prohibited by section 9 of title 13, United States Code,

shall not be transmitted to the Central Authority. The head of such department, agency, or instrumentality shall, immediately upon completion of the requested search, notify the Central Authority of the results of the search, and whether an exception set forth in paragraph (1) or (2) applies. In the event that the United States Central Authority receives information and the appropriate Federal or State department, agency, or instrumentality thereafter notifies the Central Authority that an exception set forth in paragraph (1) or (2) applies to that information, the Central Authority may not disclose that information under subsection (a).

(d) INFORMATION AVAILABLE FROM PARENT LOCATOR SERVICE.—To the extent that information which the United States Central Authority is authorized to obtain under the provisions of subsection (c) can be obtained through the Parent Locator Service, the United States Central Authority shall first seek to obtain such information from the Parent Locator Service, before requesting such information directly under the provisions of subsection (c) of this section.

(e) RECORDKEEPING.—The United States Central Authority shall maintain appropriate records concerning its activities and the disposition of cases brought to its attention.

SEC. 10. INTERAGENCY COORDINATING GROUP.

The Secretary of State, the Secretary of Health and Human Services, and the Attorney General shall designate Federal employees and may, from time to time, designate private citizens to serve on an interagency coordinating group to monitor the operation of the Convention and to provide advice on its implementation to the United States Central Authority and other Federal agencies. This group shall meet from time to time at the request of the United States Central Authority. The agency in which the United States Central Authority is located is authorized to reimburse such private citizens for travel and other expenses incurred in participating at meetings of the interagency coordinating group at rates not to exceed those authorized under subchapter I of chapter 57 of title 5, United States Code, for employees of agencies.

SEC. 11. AGREEMENT FOR USE OF PARENT LOCATOR SERVICE IN DETERMINING WHEREABOUTS OF PARENT OR CHILD.

Section 463 of the Social Security Act (42 U.S.C. 663) is amended—

(1) by striking "under this section" in subsection (b) and inserting "under subsection (a)";

(2) by striking "under this section" where it first appears in subsection (c) and inserting "under subsection (a), (b), or (e)"; and

(3) by adding at the end the following new subsection:

"(e) The Secretary shall enter into an agreement with the Central Authority designated by the President in accordance with section 7 of the International Child Abduction Remedies Act, under which the services of the Parent Locator Service established under section 453 shall be made available to such Central Authority upon its request for the purpose of locating any parent or child on behalf of an applicant to such Central Authority within the meaning of section 3(1) of that Act. The Parent Locator Service shall charge no fees for services requested pursuant to this subsection.".

SEC. 12. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated for each fiscal year such sums as may be necessary to carry out the purposes of the Convention and this Act.

PURPOSE

The purpose of H.R. 3971 is to establish court and administrative procedures for the implementation of the Hague Convention on the Civil Aspects of International Child Abduction.

BACKGROUND

In recent years, there has been growing concern about the number of instances in which children have been abducted from the custodial parent and taken to another country, often by the other parents who is involved in custody dispute regarding the child. While the States have established procedures for resolving child custody cases that involve residents of the United States, custody disputes involving residents of other countries, either from which or to which children have been abducted, raise difficult and time-consuming legal issues under the laws and customs of the respective countries.

The Hague Convention of the Civil Aspects of International Child Abduction, which is designed to address the problems unique to international child abduction cases, was signed by the United States on December 23, 1981. Its purposes were set forth by the President when he submitted the Convention to the Senate to obtain consent to its ratification:

> The Convention is designed to secure the prompt return of children who have been abducted from their country of habitual residence or wrongfully retained outside that country. It also seeks to facilitate the exercise of visitation rights across international borders. The Convention reflects a worldwide concern about the harmful effects on children of parental kidnapping and a strong desire to fashion an effective deterrent to such conduct.
>
> The Convention's approach to the problem of international child abduction is a simple one. The Convention is designed promptly to restore the factual situation that existed prior to a child's removal or retention. It does not seek to settle disputes about legal custody rights, nor does it depend upon the existence of court orders as a condition for returning children. The international abductor is denied legal advantage from the abduction to or retention in the country where the child is located, as resort to the Convention is to effect the child's swift return to his or her circumstances before the abduction or retention. In most

> cases this will mean return to the country of the child's habitual residence where any dispute about custody rights can be heard and settled.—Letter of Transmittal, President Ronald Reagan, October 30, 1985.

The Senate gave its consent to the Convention on October 9, 1986; however, the United States Government has not yet ratified the treaty because:

> The Department [of State] believes that federal legislation will be needed fully to give effect to various provisions of the Convention. . . . The United States instrument of ratification would be deposited only after satisfactory legislation has been enacted.—Letter of Submittal to the President, Secretary of State, George P. Shultz, October 4, 1985.

The Department of State submitted an Executive Communication on legislation to implement the Convention on March 6, 1987. Representative Lantos introduced the proposed legislation, H.R. 2673, in the House on June 11, 1987. This bill was referred jointly to the Judiciary Committee and the Ways and Means Committee.

There are currently 29 signatories to the Hague Convention on the Civil Aspects of Child Abduction. Nine (9) of these signatories have ratified the Convention: Australia, Canada, France, Hungary, Luxembourg, Portugal, Spain, Switzerland, and the United Kingdom.

Summary of H.R. 3971 as Recommended by the Committee

H.R. 3971 establishes court and administrative procedures for the implementation of the Hague Convention on the Civil Aspects of International Child Abduction.

The bill establishes original jurisdiction in the State Courts for actions arising under the Convention. These courts are authorized to determine the appropriate "habitual residence" of a child and to order the return of a child to that residence. The Court is required to return a child to his/her habitual residence even if there is no legal order establishing custody. Federal Court jurisdiction is retained in those cases arising under the Convention where jurisdiction exists under general law pursuant to chapter 85 of title 28.

H.R. 3971 establishes a "United States Central Authority" ("Central Authority"), which would be authorized to discharge the duties imposed on the United States by the Convention and which is directed to cooperate with the competent authorities of other ratifying countries to secure the prompt return of children and to achieve the other objectives of the Convention.

The bill provides that the Central Authority may receive and transmit any information to or from any agency, country, or person for purposes related to the Convention, in accordance with the goals and standards of the Privacy Act or any other Federal or State laws limiting the disclosure of such information. The bill also precludes disclosure where disclosure would adversely affect the national security interests of the United States, the law enforcement interests of the United States or of any state, or the confidentiality of census data. Each agency of the United States is required

to respond to a request from the Central Authority for information when the information it possesses is subject to disclosure.

H.R. 3971 provides for the establishment of the Inter-agency Coordinating Group to monitor the operation of the Convention and to provide advice on its implementation. This group will consist of federal employees appointed by the Secretaries of State and Health and Human Services and the Attorney General, and may include private citizens.

Finally, H.R. 3971 amends the Social Security Act so that the services of the Parent Locator Service will be available to the Central Authority for the purpose of locating an allegedly abducted child or abducting parent.

Committee Action

On February 3, 1988, the Subcommittee on Administrative Law and Governmental Relations held a hearing on H.R. 2673, the "International Child Abduction Act." On February 18, 1988, Mr. Lantos introduced H.R. 3971, "the International Child Abduction Act" which responded to concerns raised at the Subcommittee's hearing. H.R. 3971 is similar to H.R. 2673, but does not contain provisions amending the Social Security Act and the Internal Revenue Act of 1986, which were jointly referred to the Ways and Means Committee. H.R. 3971 as introduced contained only those provisions solely within the jurisdiction of the Committee on the Judiciary.[1]

On February 25, 1988, the Subcommittee considered H.R. 3971 and favorably recommended to the full Committee by voice vote a single amendment in the nature of a substitute.

On March 15, 1988, the full Committee considered H.R. 3971, as recommended by the Subcommittee, and after further amendments reported the bill favorably to the House with a single amendment in the nature of a substitute by voice vote.

Discussion of the Committee Amendment in the Nature of a Substitute

The amendment in the nature of a substitute recommended by the Committee includes the following modifications to H.R. 3971:

1. JURISDICTION IN STATE AND FEDERAL COURTS

The section of H.R. 3951 which is entitled "Judicial Remedies" explicitly provided that the Federal and State Courts will have jurisdiction over litigation arising from the Convention.

The amendment in the nature of a substitute redesignates this section as section 4 and adds a new subsection (a) to the section. New subsection (a)(1) of this section provides that original jurisdiction over actions arising under the Convention will be in the State Courts.

Subsection (a)(2) of the amendment explicitly retains Federal court jurisdiction in those cases arising under the Convention where such jurisdiction would exist under general law as set forth

[1] H.R. 3972, introduced by Mr. Lantos, contains the provisions relating to the Internal Revenue Service and the Social Security Act and was referred to the Committee on Ways and Means.

in chapter 85 of title 28. This would include actions covered by section 1331 (federal question); section 1332 (diversity); section 1345 (U.S. as plaintiff); section 1346 (U.S. as defendant); and section 1351 (members of diplomatic missions as defendants).

2. EVIDENCE/ADMISSIBILITY OF DOCUMENTS

The section of H.R. 3951 which is entitled "Admissibility of Documents" provides that any documents submitted in an action under the Convention are admissible without authentication. The substitute amendment clarifies this provision, now designated section 6, to ensure that documents submitted to the U.S. Central Authority or any court will require no authentication, but that all other rules of evidence or civil procedure are not affected by this provision. The waiver under this provision of any requirement for official authentication simply removes burdensome and time consuming requirements, such as the obtaining of letters rogatory from another government. It is important to note that this amended provision addresses only the issue of the admissibility of documents. For example, it does not waive the rules of evidence regarding the relevance or probative value of the documents.

3. FEDERAL ADVISORY COMMITTEE ACT

Section 10, as redesignated by the amendment in the nature of a substitute, is entitled "Interagency Coordinating Group". It provides for the establishment of a group charged with monitoring the operation of the Convention. The Group will be composed of federal employees appointed by the Secretaries of State and Health and Human Services and the Attorney General. Under H.R. 3971 as introduced the Group would have been exempt from the Federal Advisory Committee Act, which requires federal advisory groups to give public notice of their activities and to conduct meetings in public. The substitute strikes the provision for the Group's exemption from the Federal Advisory Committee Act, thus making it subject to the Act's provisions.

4. PRIVACY STATUTES

Section 8 of H.R. 3971 as introduced provided that the head of any agency or department is authorized to provide information for purposes related to the Convention to any Federal, State, or foreign authority or person, notwithstanding the Privacy Act and any other Federal or State privacy law.

This sweeping override of privacy protections could have unknown consequences. It certainly would have allowed far greater disclosure of documents relating to the treaty than is available to other individuals for any other information held by the Federal and State governments. Therefore, the Committee substitute, which redesignates this as section 9, modifies this provision in three essential ways:

(a) All federal and state agencies which provide information to the U.S. Central authority would be required to follow any applicable federal and state privacy laws.

(b) The type of information that could be given to the U.S. Central authority by federal or state agencies is limited to in-

formation which would help locate a particular child or otherwise facilitate implementation of the Convention as to a particular child.

(c) Agencies may not disclose to the U.S. Central Authority any information which would adversely affect State law enforcement interests (H.R. 3971 already has this limitation for national security matters and Federal law enforcement interests).

5. PARENT LOCATOR SERVICE

The substitute includes a new section 11, "Agreement For Use of Parent Locator Service In Determining Whereabouts of Parent or Child", at the request of the Committee on Ways and Means.[2] A similar provision was recommend in the Executive Communication on which the legislation is based and was contained in the original bill introduced by Mr. Lantos. The Committee on Ways and Means requested that the Committee on the Judiciary include this provision in H.R. 3971 so that the legislation could be acted on expeditiously by the House without the need for the Committee on Ways and Means to act on the companion bill, H.R. 3972. An explanation of the amendment was suggested by the Ways and Means Committee and adopted by the Committee on the Judiciary. The explanation follows:

USE OF THE PARENT LOCATOR SERVICE

Present Law

Section 453 of the Social Security Act, the Secretary of Health and Human Services requires to establish a Parent Locator Service (PLS) to obtain and transmit information that can help to locate an absent parent to enforce the parent's support obligations.

Section 463 of the Social Security Act authorizes the use of the Parent Locator Service in domestic parental kidnapping cases to determine the whereabouts of any absent parent or child for the purpose of: (1) enforcing any Federal or State law with respect to the unlawful taking of restraint of a child; or (2) making or enforcing a child custody determination.

The Social Security Act does not now permit the use of the Parent Locator Service in international child abduction cases.

Description of Provision

This provision would require the Secretary of Health and Human Services to enter into an agreement with the Central Authority established by this legislation. The agreement would make the services of the Parent Locator Service available to the Central Authority for the purpose of locating certain absent parents or children. Location

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[2] See Appendix for Letter of March 14, 1988, from Chairman Rostenkowski to Ghairman – Rodino.

services would be provided on behalf of any applicant to the Central Authority.

The provision would parallel the authority to provide Parent Locator Services in domestic parental kidnapping cases. Only information as to the most recent address and place of employment of the absent parent or child would be provided. The U.S. Central Authority must first seek to obtain information through the PLS, before requesting information from other departments or agencies.

The Committee intends that care be taken to protect the confidentiality of information. The Parent Locator Service would be authorized to provide information only with respect to the missing parent and child. This information only could be transmitted to a Federal, State or foreign authority or an applicant, petitioner or respondent under the terms of the Convention.

During consideration of H.R 3971, the members of the Committee discussed the appropriate burden of proof under the Act for the respondent's affirmative defenses. An amendment was offered to change the respondent's burden of proof when responding to a petition which asks for the return or a child to a "Preponderance of the evidence" from "clear and convincing evidence". The amendment was withdrawn, and during the ensuing discussion, the Committee agreed that some distinction on burden of proof should be made among the respondent's affirmative defenses. An amendment on this basis will be offered during floor consideration of the bill.

Section-by-Section Analysis of the Committee Amendment in the Nature of a Substitute

H.R. 3971

Section 1. Short Title

Section 1 provides that the short title of this bill will be the "International Child Abduction Remedies Act."

Section 2. Findings and Declarations

Section 2 states certain principles basic to the Convention and its implementation, and that the purpose of the Act is the effective implementation of the Convention. It makes clear that the provisions of the legislation are in addition to, and not in lieu of, those of the Convention. This section contains an admonition that the international character of the Convention is to be taken into consideration in its implementation, as is the need for uniformity in its interpretation in the United States. It also makes clear that procedures undertaken by the courts under the Convention and the Act are not to determine the merits of the conflicting custody claims that underlie the wrongful abduction or retention, and that such claims remain for resolution after the Convention procedures have been concluded.

Section 3. Definitions

Section 3 defines terms used in the Act and the Convention, the interpretation of which is not self-explanatory in the context of the U.S. legal system.

"Applicant" means any person who files an application with the United States Central Authority or any other Central Authority for the return of a child alleged to have been wrongfully removed or retained or for arrangements for organizing or securing the effective exercise of rights of access under the Convention.

"Convention" means the Convention on the Civil Aspects of International Child Abduction done at the Hague on October 25, 1980.

"Parent Locator Service" means the service in the Department of Health and Human Service which obtains and transmits information as to the whereabouts of any absent parent when such information is to be used to locate such parent for the purpose of enforcing support obligations against such parent.

"Petitioner" means any person who files a petition in court for relief under the Convention and this Act.

"Person" includes any individual, institution, or any other legal entity or body.

"Respondent" means any person against whom a petition is filed in accordance with this Act for relief under the Convention.

"Rights of access" means visitation rights.

"State" means any of the several states, the District of Columbia, any commonwealth, territory or possession of the United States.

"United States Central Authority" means the agency of the Federal Government designated by the President to perform on behalf of the United States the functions set forth in the Convention and Act.

Section 4

Section 4(A) expressly provides that a person seeking relief under the Convention has an original cause of action in any State court in the jurisdiction of which the child is located at the time the petition is filed. The U.S. District Courts shall have jurisdiction in cases arising under the Convention where the jurisdiction exists under title 28, U.S.C. chapter 85.

Section 4(b) provides for filing of petitions to seek the return of a child under the Convention. Petitions are to be filed with the court which has jurisdiction where the child is located.

Section 4(c) provides that notice of an action for the return of a child under the Convention and the Act is to be given in accordance with the applicable State or other law governing notice in interstate child custody cases. This will provide the necessary guidance for notice, for example, when the child is located in one U.S. jurisdiction and the respondent is located in another jurisdiction.

Section 4(d) provides that the court in which an action is brought shall decide the case in accordance with the Convention.

Section 4(e) makes clear that the courts are to order the prompt return of a child when the parent seeking return of the child under the Convention establishes by a preponderance of the evidence that the child has been wrongfully removed or retained within the

meaning of the Convention. The respondent, on the other hand, must demonstrate by clear and convincing evidence that one of the exceptions provided by the Convention applies. The respondent must meet a higher burden of proof in order to provide any basis for return to be refused.

Section 4(f) provides that in an action brought under this Act, these terms have a defined meaning:

"Authorities", as used in Article 15 of the Convention, includes public officials and courts.

"Wrongful removal or retention" includes a removal or retention even when the child has not yet become the subject of a custody order, notwithstanding that the law of the State in which the child is located may not make the taking or retention in such circumstances a felony or otherwise wrongful.

"Commencement of the proceedings", within the meaning of Article 12 of the Convention, means the filing of a petition in accordance with section 102(b) of the Act. Under Article 12, so long as the commencement of proceedings takes place less than one year after the wrongful removal or retention, the judicial authority is to order the return of the child forthwith and without regard for any demonstration that the child may have become settled in its new environment.

Section 4(g) provides that full faith and credit shall be accorded throughout the United States to judgments and orders of courts in the United States rendered with regard to return actions pursuant to the Convention and the Act. This means, for example, that if a court in one jurisdiction has ordered the return of a child and the child is located in another jurisdiction in the United States before that order has been executed, the order shall be given full effect in the second jurisdiction without the need to initiate a new return action there pursuant to the Convention and the Act. It also means that if the return request is denied, the court's decision shall be recognized by courts in other jurisdictions. However, the provision is not intended to deny the possibility of appeal from a return order or a decision denying a return order.

Section 4(h) makes clear that the remedies under the Convention and the Act are in addition to remedies otherwise available, and are not intended to replace or exclude other available remedies that exist or may be established under law in the United States, such as the Uniform Child Custody Jurisdiction Act (UCCJA).

Section 5. Provisional Remedies

Section 5(a) provides that any court may take or cause to be taken provisional measures under State or Federal law, as appropriate, to protect the child from neglect or abuse or to prevent its removal from the jurisdiction or its concealment while the petition filed pursuant to the Convention and this Act is pending.

Section 5(b) provides that the requirements of the law of the jurisdiction where the child is located must be satisfied for removal of the child from the physical custody of a person having such custody. While the meaning of this provision for State courts is clear, it also means that Federal district courts must similarly apply local law in this regard. It will be up to Federal courts, by appropriate arrangements with State or local authorities, to make provision for

such matters as foster care by State or local authorities. Care provisions in such situations would presumably have been ordered by State courts if the action concerning a particular child had been brought before a State rather than a Federal court.

Section 6. Admissibility of Documents

Section 6 ensures that documents submitted in support of an application for assistance addressed to the United States Central Authority or a petition to a court in an action pursuant to the Convention and the Act will be admissible without any need for legalization or authentication. Rules of evidence or civil procedures are not affected by this provision. The waiver under this provision of any requirement for official authentication simply removes burdensome and time consuming requirements, such as the obtaining of letters rogatory from another government. It is important to note that this amended provision addresses only the issue of the admissibility of documents. For example, it does not waive the rules of evidence regarding the relevance or probative value of the documents.

Section 7. United States Central Authority

Section 7(a) provides for the establishment of the United States Central Authority in an existing Federal agency.

Subsection 7(b) makes clear that the functions of the Central Authority ascribed to it by the Convention and the Act are to be carried out by the United States Central Authority.

Subsection 7(c) expressly authorizes the United States Central Authority to issue regulations in connection with the implementation of the Convention and the Act.

Subsection 7(d) authorizes the United States Central Authority to make use of the services of the Parent Locator Service (PLS) to the extent authorized by the Social Security Act.

Section 8. Costs and Fees

Section 8(a) ensures that, consistent with the obligation in the first paragraph of Article 26 of the Convention, none of the costs for the administrative processing of applications under the Convention are imposed on the applicant by the United States Central Authority, any Federal agency, or any cooperating State or local authorities.

Section 8(b)(1) provides that petitioners may be required to bear the costs of legal fees and court costs in connection with their petitions, and travel costs associated with the return of a child. This is consistent with the State Department's proposal that the United States ratify the Convention subject to a reservation, permitted by Article 42 (to be made by declaration at the time of ratification) that the United States will not be bound to assume any costs referred to in the second paragraph of Article 26 resulting from the participation of legal counsel or advisers or from court proceedings. The advice and consent to ratification of the Convention given by the U.S. Senate on October 9, 1986, was made subject to this reservation.

Section 8(b)(2) provides that legal fees and court costs not covered by Federal, State, or local legal assistance or other programs are to be borne by the petitioner, but subject to subsection (b)(3).

Section 8(b)(3), reflecting the provisions of the last paragraph of Article 26 of the Convention, provides that a court ordering the return of a child shall order the respondent to pay specified necessary expenses incurred by or on behalf of the petitioner unless the respondent establishes that to do so would be clearly inappropriate. This provision of the Act, and the provision of Article 26 that it reflects, were intended to provide an additional deterrent to wrongful international child removals and retentions.

Section 9. Collection, Maintenance and Dissemination of Information

Section 9(a) provides for the United States Central Authority, in pursuance of its functions under the Convention, to receive and transmit information regarding the location of a child with agencies, departments, or instrumentalities of the Federal or state Governments in conformance with applicable federal and state privacy laws.

Section 9(b) permits the United States Central Authority to prescribe by regulation how and subject to what exceptions requests for information shall be submitted to it and what supporting documents may be required.

Section 9(c) requires each federal agency or any state to provide information requested by the United States Central Authority in compliance with any applicable federal and state privacy laws. Information given to the U.S. Central Authority by federal or state agencies is limited to information which would help locate a particular child or implement the Convention as to a particular child. Agencies may not disclose to the U.S. Central Authority information which would adversely affect state or federal law enforcement interests or national security interests.

Section 9(d) requires the United States Central Authority to obtain from the Parent Locator Service (PLS) any information in the control of a Federal Agency that can be obtained through the FPLS and that the FPLS is authorized to provide to the Authority, rather than requesting such information directly from that agency.

Section 9(e) requires that the Central Authority maintain appropriate records concerning its functions and the disposition of cases arising under the Convention.

Section 10. Inter-Agency Coordinating Group

Section 10 provides for the establishment of the Inter-agency Coordinating Group to monitor operation of the Convention and provide advice on its implementation in the United States. This group will consist of federal employees appointed by the Secretaries of State and Health and Human Services and the Attorney General, and may also include expert private citizens. The group shall meet at the request of the United States Central Authority.

Section 11. Agreement For Use of Parent Locator Service In Determining Whereabouts of Parent or Child

Section 12 authorizes the Secretary of Health and Human Services to enter into an agreement with the Central Authority to make the service's of the Parent Locator Service available to the Central Authority for the location of absent parents or children. The authority would parallel that granted to Parent Locator services in domestic parental kidnapping cases. The U.S. Central Authority must first seek information through the PLS, before requesting information from other departments or agencies.

Section 12. Authorization of Appropriations

Section 12 authorizes the appropriation of such sums as may be necessary each fiscal year to carry out the purposes of the Convention and this Act. The purpose of this section is to provide for the contingency that funds may be needed to carry out these functions.

STATEMENTS UNDER RULE XI, CLAUSE 2(l)(2)(B), CLAUSE 2(l)(3)(A), CLAUSE 2(l)(3)B), CLAUSE 2(l)(3)(D), AND CLAUSE 2(l)(4); RULE XIII, CLAUSE (7)(a)(1); AND RULE XI, CLAUSE 2(l)(3)(C); AND RULE XIII, CLAUSE (3)

COMMITTEE VOTE

(Rule XI (2)(l)(2)(B))

On March 15, 1988, a reporting quorum being present, the full Committee on the Judiciary approved the bill, H.R. 3971, by a voice vote.

OVERSIGHT STATEMENT

(Rule XI (2)(l)(3)(A))

The Subcommitte on Administrative Law and Governmental Relations of this Committee exercises the Committee's oversight responsibility with reference to administrative procedure and the courts in accordance with Rule VI(b) of the Rules of the Committee. The favorable consideration of this bill was recommended by the Subcommittee and the Committee determined that the legislation should be enacted as set forth in this bill.

BUDGET STATEMENT

(Rule XI (2)(l)(3)(B))

H.R. 3971 does not directly provide budget authority nor does it involve new or increased tax expenditures contemplated by Clause 2(l)(3)(B) of Rule XI.

OVERSIGHT FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE ON GOVERNMENT OPERATIONS

(Rule XI (2)(l)(3)(D))

No findings or recommendations of the Committee on Government Operations were received as referred to in subdivision (d) of clause 2(l)(3) of House Rule XI.

INFLATIONARY IMPACT

(Rule XI (2)(l)(4))

In compliance with clause 2(l)(4) of House Rule XI, it is stated that this legislation will have no inflationary impact on prices and costs on the operation of the national economy.

COST

(Rule XIII (7)(a)(1))

The costs are those outlined in the cost estimate of the Congressional Budget Office included in this report.

COST ESTIMATE OF THE CONGRESSIONAL BUDGET OFFICE

(Rule XI 2(l)(3)(C))

The cost estimate of the Congressional Budget Office, prepared pursuant to section 403 of the Congressional Budget Act of 1974 and received by the Committee on March 22, 1988, is as follows:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, March 22, 1988.

Hon. PETER W. RODINO, Jr.,
Chairman, Committee on the Judiciary,
House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has reviewed H.R. 3971, the International Child Abduction Remedies Act, as ordered reported by the House Committee on the Judiciary, March 15, 1988.

H.R. 3971 would implement the 1980 Hague Convention on the Civil Aspects of International Child Abduction. The Convention requires that nations establish a central authority on international child abduction to respond to requests for information. H.R. 3971 would authorize the appropriation of the necessary sums to carry out these purposes.

It is difficult to project what costs, if any, would result from enacting H.R. 3971 because there is little available information on international child abduction. The potential costs depend on the number of petitions filed for the return of abducted children and the difficulties encountered locating them and securing their return. Based on information provided by the Department of State, CBO expects that additional costs to the federal government are not likely to be substantial—probably well below $1 million annually.

This bill would result in some additional costs to state and local governments because the responsibility for locating abducted children and providing foster care would rest with state and local governments. Additionally, H.R. 3971 would empower state courts with original jurisdiction over cases brought under the Convention. Because the number of cases is likely to be small, additional costs to state and local governments are not likely to be significant.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

JAMES L. BLUM,
Acting Director.

The following Executive Communication was submitted by the U.S. Department of State to the House of Representatives on March 6, 1987:

U.S. DEPARTMENT OF STATE,
Washington, DC, March 9, 1987.

Hon. JAMES C. WRIGHT, Jr.,
Speaker, House of Representatives,
Washington, DC.

DEAR MR. SPEAKER: I have the honor to transmit for the consideration of the Congress the draft of a bill to ensure the appropriate implementation in the United States of the 1980 Hague Convention on the Civil Aspects of International Child Abduction. The Convention was transmitted to the United States Senate by President Reagan for advice and consent to ratification on October 30, 1985 (Senate Treaty Doc. 99-11), and the United States Senate on October 9, 1986 gave its advice and consent to U.S. ratification. The United States instrument of ratification will be deposited with the Ministry of Foreign Affairs of the Kingdom of the Netherlands once the bill has been enacted into law. The Convention will enter into force for the United States on the first day of the third calendar month after the deposit of the U.S. instrument of ratification.

The Convention has entered into force between Canada, France, Portugal, Switzerland, the United Kingdom, Hungary, Luxembourg and Australia. The United States signed the Convention on December 23, 1981 after the American Bar Association and the Secretary of State's Advisory Committee on Private International Law had endorsed it for signature and ratification by the United States.

The Convention seeks to deal with the intractable problem of international abductions or retentions of children in custody-related disputes by providing a treaty obligation for the prompt return of such children.

The draft bill was prepared by the Department of State in consultation with the Departments of Justice and Health and Human Services and private sector study group consisting of practicing attorneys, law professors and State officials expert in the legal aspects of child custody problems. The provisions of the bill expressly address certain questions that might arise in connection with implementation of the Convention in the context of the United States legal system. It is hoped that enactment of the bill will ensure greater uniformity in the Convention's implementation and inter-

pretation in the United States, and will shorten the running-in period for effective U.S. implementation. It is also hoped that it will enhance the effectiveness of the Convention as a deterrent to future wrongful removals or retentions of children between the United States and other States party to the Convention.

The scope of the problem addressed by the Convention for the United States is evident from statistics available to the Department of State on just those cases brought to its attention. As of May 1, 1983 the Department knew of 667 unresolved cases of child abductions from the United States; as of December 31, 1986 such cases totaled 2,353. The Department's statistics suggest that children abducted from the United States and retained outside the United States currently average at least 35 per month.

Prompt enactment by Congress of federal legislation and U.S. ratification of the Convention will permit future left-behind parents in the United States to benefit from this Convention in the event of child abductions or retentions involving other countries that are parties to the Convention, and will undoubtedly encourage more rapid and widespread ratification of the Convention by other countries.

The Office of Management and Budget has advised that there is no objection to the presentation of this proposal to the Congress, and that its enactment would be in accord with the program of the President.

With best wished,

Sincerely,

J. EDWARD FOX,
Assistant Secretary,
Legislative and Intergovernmental Affairs.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rues of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SECTION 463 OF THE SOCIAL SECURITY ACT

USE OF FEDERAL PARENT LOCATOR SERVICE IN CONNECTION WITH THE ENFORCEMENT OR DETERMINATION OF CHILD CUSTODY AND IN CASES OF PARENTAL KIDNAPING OF A CHILD

SEC. 463. (a) * * *

(b) An agreement entered into [under this section] *under subsection (a)* shall provide that the State agency described in section 454 will, under procedures prescribed by the Secretary in regulations, receive and transmit to the Secretary requests from authorized persons for information as to (or useful in determining) the whereabouts of any absent parent or child when such information is to be used to locate such parent or child for the purpose of—

(1) enforcing any State or Federal law with respect to the unlawful taking or restraint of a child; or

(2) making or enforcing a child custody determination.

(c) Information authorized to be provided by the Secretary under [this section] *subsection (a), (b), or (e)* shall be subject to the same conditions with respect to disclosure as information authorized to be provided under section 453, and a request for information by the Secretary under this section shall be considered to be a request for information under section 453 which is authorized to be provided under such section. Only information as to the most recent address and place of employment of any absent parent or child shall be provided under this section.

* * * * * * *

(e) The Secretary shall enter into an agreement with the Central Authority designated by the President in accordance with section 7 of the International Child Abduction Remedies Act, under which the services of the Parent Locator Service established under section 453 shall be made available to such Central Authority upon its request for the purpose of locating any parent or child on behalf of an applicant to such Central Authority within the meaning of section 3(1) of that Act. The Parent Locator Service shall charge no fees for services requested pursuant to this subsection.

APPENDIX

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC, March 14, 1988.

Hon. PETER W. RODINO, Jr.,
Chairman, Committee on the Judiciary, House of Representatives, Rayburn House Office, Washington, DC.

DEAR MR. CHAIRMAN: I am writing to you concerning legislation to implement the Hague Convention on the Civil Aspects of International Child Abduction, a treaty that has been negotiated to facilitate resolution of international child kidnapping cases.

As you know, there are two companion bills in the House which are necessary to implement this treaty. H.R. 3971 has been referred to your Committee and may soon be ordered reported. H.R. 3972 has been referred to the Committee on Ways and Means; no action has been taken to date on this bill.

In order to facilitate action on this important issue, I would request that an amendment which would constitute action by the Committee on Ways and Means on H.R. 3972 be adopted during your Committee's deliberation on H.R. 3971.

I have reviewed the amendment in the nature of a substitute that has been recommended by the Subcommittee on Administrative Law and Governmental Relations, as well as the Frank amendment with respect to the application of the Privacy Act to the release of information under the bill. I support both and am particularly pleased that the Frank amendment makes clear that the provisions of the Privacy Act may not be waived by the Central Authority established pursuant to this legislation. Sharing information about the possible whereabouts of kidnapped children is important but in doing so we must be careful not to violate the privacy of other citizens. Limiting the information that can be released to the most recent address and place of employment of the absent parent and child, as section 463 of the Social Security Act provides, and assuring that the basic provisions of the Privacy Act also apply will protect against the inappropriate release of information.

Assuming adoption by your Committee of the Frank amendment, I would propose an amendment that consists of two provisions. First, it would delete section 9(e) of the amendment in the nature of a substitute concerning the ability of the Central Authority to obtain tax return information. This provision is unnecessary. The Parent Locator Service, established in section 453 of the Social Security Act, has access to all of the required information under current law.

Second, the amendment would add a new section 11 to the amendment in the nature of a substitute. Section 11 would amend section 463 of the Social Security Act, permitting the federal Parent Locator Service to share certain information with the Central Authority in international kidnapping cases. A copy of the amendment and proposed report language describing it are attached.

Adoption of this proposed amendment by your Committee would enable your Committee to move quickly to the House floor subsequent to your action on H.R. 3971, and eliminate the need for the Committee on Ways and Means to act on the companion bill H.R. 3972. In order to constitute legislative history I would request that my letter also be printed in your Committee report on H.R. 3971.

With warm regards, I am

Sincerely yours,

DAN ROSTENKOWSKI,
Chairman.

AMENDMENTS TO THE AMENDMENT IN THE NATURE OF A SUBSTITUTE TO H.R. 3971

Strike "Federal" in section 3(4), in section 7(d), and each place it appears in section 9(d).

Strike subsection (e) of section 9 and redesignate the succeeding subsection accordingly.

Redesignate section 11 as section 12, and insert after section 10 the following new section:

SEC. 11. AGREEMENT FOR USE OF PARENT LOCATOR SERVICE IN DETERMINING WHEREABOUTS OF PARENT OR CHILD.

Section 463 of the Social Security Act (42 U.S.C. 663) is amended—

(1) by striking "under this section" in subsection (b) and inserting "under subsection (a)";

(2) by striking "under this section" where it first appears in subsection (c) and inserting "under subsection (a), (b), or (e)"; and

(3) by adding at the end the following new subsection:

"(e) The Secretary shall enter into an agreement with the Central Authority designated by the President in accordance with section 6 of the International Child Abduction Remedies Act, under which the services of the Parent Locator Service established under section 453 shall be made available to such Central Authority upon its request for the purpose of locating any parent or child on behalf of an applicant to such Central Authority within the meaning of section 2(1) of that Act. The Parent Locator Service shall charge no fees for services requested pursuant to this subsection.".

AMENDMENT TO H.R. 3971 PROPOSED REPORT LANGUAGE

USE OF THE PARENT LOCATOR SERVICE

Present Law

Section 453 of the Social Security Act requires the Secretary of Health and Human Services to establish a Parent Locator Service (PLS) to obtain and transmit information that can help to locate an absent parent to enforce the parent's support obligations.

Section 463 of the Social Security Act authorizes the use of the Parent Locator Service in domestic parental kidnapping cases to determine the whereabouts of any absent parent or child for the purpose of: (1) enforcing any Federal or State law with respect to the unlawful taking or restraint of a child; or (2) making or enforcing a child custody determination.

The Social Security Act does not now permit the use of the Parent Locator Service in international child abduction cases.

Description of Provision

This provision would require the Secretary of Health and Human Services to enter into an agreement with the Central Authority established by this legislation. The agreement would make the services of the Parent Locator Service available to the Central Authority for the purpose of locating certain absent parents or children. Location services would be provided on behalf of any applicant to the Central Authority.

The provision would parallel the authority to provide Parent Locator Services in domestic parental kidnapping cases. Only information as to the most recent address and place of employment of the absent parent or child would be provided. The U.S. Central Authority must first seek to obtain information through the PLS, before requesting information from other departments or agencies.

The Committee intends that care be taken to protect the confidentiality of information. The Parent Locator Service would be authorized to provide information only with respect to the missing parent and child. This information only could be transmitted to a Federal, State or foreign authority or an applicant, petitioner or respondent under the terms of the Convention.

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Finder's Aid

P.L. 100-360 (102 Stat. 683) Approved July 1, 1988
"Medicare Catastrophic Coverage Act of 1988"

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Trust Funds--Transfers	201(g) (1)(A)	212(c)(1) (A)	741	--	--	62, 157, 160, 166, 220-222
Trust Funds--Transfers	201(i) (1)	212(c)(1) (B)	741	--	--	62, 157, 160, 166, 220-222
Entitlement to Hospital Insurance Benefits	226(b)	411(n)(1)	807	--	--	131, 270-273
Maternal and Child Health Services Block Grant--Use of Allotment Funds	504(b) (6)	411(k)(10) (D)	795	--	--	120, 270-273
Administration--Office of Rural Health Policy (technical amendment)	711(b) (1)	411(m)(1)	806	--	--	130, 270-273
General Provisions--Exclusions from Participation in Health Care Programs	1128(b) (8)(A) (i)	411(k)(10) (D)	795	--	--	119, 270-273
General Provisions--Exclusions from Participation in Health Care Programs	1128(d) (1)	411(k)(10) (D)	795	--	--	119, 270-273
General Provisions--Exclusions from Participation in Health Care Programs	1128(d) (3)(A)	411(k)(10) (D)	795	--	--	119, 270-273

*NOTE: Page numbers are preceded by the number of the part in which they appear.

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
General Provisions--Exclusions from Participation in Health Care Programs	1128(d)(3)(B)(ii)	411(k)(10)(C)	795	--	--	119, 270-273
General Provisions--Exclusions from Participation in Health Care Programs	1128(i)	411(k)(10)(D)	795	--	--	119, 270-273
General Provisions--Exclusions from Participation in Health Care Programs	1128(i)(1)	411(k)(10)(D)	795	--	--	119, 270-273
General Provisions--Exclusions from Participation in Health Care Programs	1128(i)(2)	411(k)(10)(D)	795	--	--	119, 270-273
General Provisions--Exclusions from Participation in Health Care Programs	1128(i)(3)	411(k)(10)(D)	795	--	--	119, 270-273
General Provisions--Exclusions from Participation in Health Care Programs	1128(i)(4)	411(k)(10)(D)	795	--	--	119, 270-273
General Provisions--Exclusions from Participation in Health Care Programs	1128(i)(4)	411(k)(10)(D)	795	--	--	119, 270-273
General Provisions--Civil Monetary Penalties	1128A(a)	411(k)(10)(D)	795	--	--	119, 270-273
General Provisions--Civil Monetary Penalties	1128A(a)	411(k)(10)(B)(ii)(II)	795	--	--	119, 270-273
General Provisions--Civil Monetary Penalties (technical amendment)	1128A(a)(1)	202(c)(2)(A)	715	--	--	35, 173-199
General Provisions--Civil Monetary Penalties	1128A(a)(1)(D)	411(k)(10)(D)	795	2/46-51	--	119, 270-273
General Provisions--Civil Monetary Penalties	1128A(a)(1)(D)	411(k)(10)(D)	795	--	--	119, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
General Provisions--Civil Monetary Penalties	1128A(a) (2)(C)	202(c)(2) (B)	715	2/46-51	--	35, 173-199
General Provisions--Civil Monetary Penalties (technical amendment)	1128A(a) (2)	202(c)(2) (C)	715	2/46-51	--	35, 173-199
General Provisions--Civil Monetary Penalties (technical amendment)	1128A(a) (3)	202(c)(2) (D)	715	2/46-51	--	35, 173-199
General Provisions--Civil Monetary Penalties	1128A(a)(4) New	202(c)(2) (E)	715	2/46-51	--	35, 173-199
General Provisions--Civil Monetary Penalties	1128A(b) (1)(A)	411(e)(3)	775	--	--	98, 270-273
General Provisions--Civil Monetary Penalties	1128A(b) (2)	411(e)(3)	775	--	--	98, 270-273
General Provisions--Civil Monetary Penalties	1128A(c) (1)	411(k)(10) (D)	795	--	--	119, 270-273
General Provisions--Civil Monetary Penalties	1128A(c) (1)	411(k)(10) (D)	795	--	--	119, 270-273
General Provisions--Civil Monetary Penalties	1128A(i)	411(k)(10) (D)	795	--	--	119, 270-273
General Provisions--Civil Monetary Penalties	1128A(i) (1)	411(k)(10) (D)	795	--	--	119, 270-273
General Provisions--Civil Monetary Penalties	1128A(i) (2)	411(k)(10) (D)	795	--	--	120, 270-273
General Provisions--Civil Monetary Penalties	1128A(i) (5) New	411(k)(10) (D)	795	--	--	120, 270-273
General Provisions--Civil Monetary Penalties	1128A(l)	411(k)(10) (B)(ii) (III)	795	--	--	119, 270-273
General Provisions--Model Prospective Rate Methodology (technical amendment)	1135(d) (3)	411(g)(6)	785	--	--	109, 270-273
General Provisions--Income and Eligibility Verification System	1137(f) New	411(k)(15) (A)	799	--	--	123, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
General Provisions--Organ Procurement (technical amendment)	1138(a)(1)(B)	411(e)(3)	775	--	--	98, 270-273
General Provisions--Prohibition of Misuse of Symbols, Emblems, or Names in Reference to Social Security or Medicare	1140 New	428(a)	815	--	--	140-142 239-240
General Provisions--Functions of Peer Review Organizations	1154(a)(3)	411(j)(2)	791	--	--	114, 270-273
General Provisions--Functions of Peer Review Organizations	1154(a)(4)(B)	411(e)(3)	775	--	--	98, 270-273
General Provisions--Functions of Peer Review Organizations (technical amendment)	1154(a)(4)(B)	411(e)(3)	775	--	--	98, 270-273
General Provisions--Functions of Peer Review Organizations (technical amendment)	1154(a)(4)(C)	411(e)(3)	775	--	--	98 270-273
General Provisions--Functions of Peer Review Organizations (technical amendment)	1154(a)(4)(C)(i)	411(e)(3)	775	--	--	98, 270-273
General Provisions--Functions of Peer Review Organizations (technical amendment)	1154(a)(15)	411(j)(3)(B)	791	--	--	114, 270-273
General Provisions--Functions of Peer Review Organizations	1154(a)(16) New	203(d)(2)	724	--	--	45, 199-204
General Provisions--Functions of Peer Review Organizations	1154(d)	411(e)(3)	775	--	--	98, 270-273
General Provisions--Functions of Peer Review Organizations	1154(e)(3)(A)(i)	411(j)(4)(C)	791	--	--	115, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
General Provisions--Functions of Peer Review Organizations	1154(e)(3)(B)	411(j)(4)(C)	791	--	--	115, 270-273
General Provisions--Obligations of Health Care Practitioners	1156(b)(1)	411(e)(3)	775	--	--	98, 270-273
General Provisions--Obligations of Health Care Practitioners	1156(b)(2)	411(e)(3)	775	--	--	98, 270-273
General Provisions--Peer Review--Prohibition Against Disclosure of Information	1160(e) New	411(e)(3)	776	--	--	98, 270-273
Supplemental Security Income--Policy Regarding Disposal of Resources (conforming amendment)	1611(e)(1)(B)	303(c)(2)	762	--	--	85, 257-269
Supplemental Security Income--Policy Regarding Disposal of Resources	1613(c)	303(c)(1)	762	--	--	84-85, 257-269
Medicare--Notice of Benefits	1804 New	223(a)	747	1/25, 45-46 2/17, 56-57, 98	13-14	68-69 228-230
Medicare--Hospital Insurance Benefits	1811	104(d)(1)	688	1/46 2/98-99	41	7, 146-149
Medicare--Scope of Benefits	1812(a)(1)	101(1)	684	1/9-14, 46 2/38-40, 99	5-6, 41-44	3, 146-152
Medicare--Scope of Benefits	1812(a)(2)	101(1)	684	1/9-14, 46 2/38-40, 99	5-6, 41-44	3, 146-152
Medicare--Scope of Benefits	1812(a)(3)	101(1)	684	1/9-14, 46 2/38-40, 99	5-6, 41-44	3, 146-152

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Scope of Benefits	1812(a)(4)	101(1)	684	1/9-14, 46 2/38-40, 99	5-6, 41-44	3, 146-152
Medicare--Scope of Benefits	1812(b)	101(2)	685	1/9-14, 47 2/38-40, 99	5-6, 42-44	3, 146-152
Medicare--Scope of Benefits	1812(c)	101(3)	685	1/9-14, 47-48 2/38-40, 99-100	5-6, 42-45	3-4, 146-152
Medicare--Scope of Benefits	1812(d)(1)	101(4)(A)	685	1/9-14, 48 2/38-40, 100	--	4, 146-152
Medicare--Scope of Benefits	1812(d)(2)(B)	101(4)(B)	685	1/9-14, 48 2/38-40, 100	--	4, 146-152
Medicare--Scope of Benefits	1812(e)	101(5)	685	1/9-14, 48 2/38-40, 100	--	4, 146-152
Medicare--Scope of Benefits	1812(f) Stricken	101(6)	685	1/9-14, 48 2/38-40, 100	5-6, 43	4, 146-152
Medicare--Scope of Benefits	1812(g) Stricken	101(6)	685	1/9-14, 48 2/38-40, 100	5-6, 43	4, 146-152
Medicare--Deductibles and Coinsurance	1813(a)(1)	102(1)	685	1/9-14 2/40, 101	6-7, 47-49	4-5, 146-149
Medicare--Deductibles and Coinsurance	1813(a)(2)	102(1)	685	1/9-14, 49 2/40, 102	6-7, 47-49	5, 146-149
Medicare--Deductibles and Coinsurance	1813(a)(3)	102(1)	685	1/9-14, 50 2/40, 103	6-7, 47-49	5, 146-149

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Deductibles and Coinsurance	1813(b) (1)	411(b)(1) (A)(ii)	769	2/102-103	--	92, 270-273
Medicare--Deductibles and Coinsurance	1813(b) (3) Stricken	102(2)	687	1/9-14, 50 2/40, 103	6-7, 48	5, 146-149
Medicare--Conditions of and Limitations on Payments for Services	1814(a) (2)(B)	104(d)(2) (A)	688	1/51 2/104	--	7, 146-149
Medicare--Conditions of and Limitations on Payments for Services	1814(a) (2)(B)	104(d)(2) (B)	688	1/9-14, 51 2/104	--	7, 146-149
Medicare--Conditions of and Limitations on Payments for Services	1814(a) (6)	104(d)(2) (A)	688	1/9-14, 51 2/104	--	7, 146-149
Medicare--Conditions of and Limitations on Payments for Services (technical amendment)	1814(a) (7)(A) (i)	104(d)(2) (C)(i)	688	1/9-14, 52 2/104	53	7, 146-149
Medicare--Conditions of and Limitations on Payments for Services	1814(a) (7)(A) (ii)	104(d)(2) (C)(ii)	689	1/9-14, 52 2/104	53	7, 146-149
Medicare--Conditions of and Limitations on Payments for Services	1814(a) (7)(A) (iii) New	104(d)(2) (C)(iii)	689	1/52 2/104	53	7, 146-149
Medicare--Conditions of and Limitations on Payments for Services	1814(d) (3)	104(d)(2) (D)(i)	689	1/52 2/105	--	7, 146-149
Medicare--Conditions of and Limitations on Payments for Services	1814(d) (3)	104(d)(2) (D)(ii)	689	1/52	--	7, 146-149
Medicare--Use of Public Agencies or Private Organizations--Payment to Providers	1816(j) (2)	411(e)(1) (B)(i)	775	--	--	98, 270-273
Medicare--Use of Public Agencies or Private Organizations--Payment to Providers	1816(j) (2)	411(e)(1) (B)(ii)	775	--	--	98, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Use of Public Agencies or Private Organizations--Payment to Providers	1816(k) New	203(f)	725	--	--	46, 199-204
Medicare--Trust Fund--Transfers	1817(b)	212(c)(3)	741	--	--	62, 157, 160, 166, 220-222
Medicare--Federal Hospital Insurance Catastrophic Coverage Reserve Fund	1817A New	112(a)	698	--	--	17-18, 152-166
Medicare--Hospital Insurance Benefits for Uninsured Individuals	1818(c) (4) Stricken	411(b)(8) (D)	772	--	--	95, 270-273
Medicare--Hospital Insurance Benefits for Uninsured Individuals (technical amendment)	1818(c)(5) Redesignated as 1818(c) (4)	411(b)(8) (D)	772	--	--	95, 270-273
Medicare--Hospital Insurance Benefits for Uninsured Individuals (technical amendment)	1818(c)(6) Redesignated as 1818(c) (5)	411(b)(8) (D)	772	--	--	95, 270-273
Medicare--Hospital Insurance Benefits for Uninsured Individuals (technical amendment)	1818(c)(7) Redesignated as 1818(c) (6)	411(b)(8) (D)	772	--	--	95, 270-273
Medicare--Hospital Insurance Benefits for Uninsured Individuals	1818(d)	103	687	1/52-53 2/42-44, 105-106	--	6, 146-149
Medicare--Requirements for Skilled Nursing Facilities	1819(b) (3)(A) (iii)	411(b)(2) (B)	801	--	--	126, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(b) (3)(A) (iv)	411(b)(2) (A)	801	--	--	125, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(b) (3)(B) (ii)(III)	411(b)(2) (C)	801	--	--	126, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Requirements for Skilled Nursing Facilities	1819(b) (3)(C) (i)(I)	411(f)(1) (A)(i)	800	--	--	125, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(b) (4)(C) (i)	411(f)(1) (A)(ii) (I)	800	--	--	125, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(b) (4)(C) (i)	411(f)(1) (A)(ii) (II)	801	--	--	125, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(b) (4)(C) (i)	411(f)(1) (A)(ii) (III)	801	--	--	125, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(b) (5)(A)	411(f)(1) (A)(iii)	801	--	--	125, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(b) (5)(A)	411(f)(2) (D)(i)	802	--	--	126, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(b) (5)(A) (ii)	411(f)(2) (D)(ii)	802	--	--	126, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(b) (5)(G)	411(f)(2) (D)(iii)	802	--	--	126, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(c) (2)(A) (v)	411(f)(2) (F)	802	--	--	126, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(c) (6)(A) (ii)	411(f)(2) (G)(i)	802	--	--	126, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(c) (6)(B)	411(f)(2) (G)(ii)	802	--	--	126, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(e) (1)(A)	411(f)(1) (A)(iv)	801	--	--	125, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Requirements for Skilled Nursing Facilities	1819(e) (1)(B)	411(l)(1) (A)(v)	801	--	--	125, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(e) (2)(A)	411(l)(1) (A)(vi)	801	--	--	125, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(e) (2)(B)	411(l)(2) (H)	802	--	--	126, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(e) (3)	411(l)(1) (A)(vii)	801	--	--	125, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(e) (3)	411(l)(2) (I)(i)	802	--	--	127, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(e) (3)	411(l)(2) (I)(ii)	802	--	--	127, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(e) (5)	411(l)(1) (A)(viii)	801	--	--	125, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(f) (2)(A) (i)(I)	411(l)(2) (J)	802	--	--	127, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(f) (3)	411(l)(1) (A)(ix)	801	--	--	125, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(f) (3)	411(l)(2) (I)(i)	802	--	--	127, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(f) (3)	411(l)(2) (I)(ii)	802	--	--	127, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(f) (6)(A)	411(l)(1) (A)(x)	801	--	--	125, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Requirements for Skilled Nursing Facilities	1819(f) (6)(B)	411(f)(1) (A)(xi)	801	--	--	125, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(f) (7)	411(f)(2) (K)	802	--	--	127, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(f) (7)(B)	411(f)(2) (L)(i)	802	--	--	127, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(g) (1)(C)	411(f)(5) (A)	804	--	--	128, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(g) (1)(C)	411(f)(5) (B)	804	--	--	128, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(g) (1)(C)	411(f)(5) (C)	804	--	--	128, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(g) (1)(D)	411(f)(5) (D)	804	--	--	128, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(g) (2)(A) (i)	411(f)(5) (E)	804	--	--	128, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(g) (2)(C) (i)	411(f)(4)	803	--	--	128, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(g) (3)(D)	411(f)(5) (F)	804	--	--	129, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(g) (4)	411(f)(5) (G)	804	--	--	129, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1819(h) (2)(B) (ii)	411(f)(7) (A)	805	--	--	129, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Requirements for Skilled Nursing Facilities	1819(h) (6)	411(b)(7) (B)	805	--	--	129, 270-273
Medicare--Requirements for Skilled Nursing Facilities	1832(a) (2)(A)	203(a)	721	--	--	41, 199-204
Medicare--In-Home Care for Certain Chronically Dependent Individuals (technical amendment)	1832(a) (2)(A) Redesignated as 1832(a) (2)(A)(i)	205(a)(1) (A)	729	2/51-53, 106	--	50, 204-206
Medicare--In-Home Care for Certain Chronically Dependent Individuals (technical amendment)	1832(a) (2)(A) (i)	205(a)(1) (B)	729	2/12, 51-53, 106	--	50, 204-206
Medicare--In-Home Care for Certain Chronically Dependent Individuals	1832(a) (2)(A) (ii) New	205(a)(1) (B)	729	2/51-53	--	50, 204-206
Medicare--Supplementary Medical Insurance Benefits	1832(a) (2)(B) (ii)	411(h)(4) (A)	786	--	--	109, 270-273
Medicare--Supplementary Medical Insurance Benefits	1832(a) (2)(B) (ii)	411(h)(7) (B)	787	--	--	111, 270-273
Medicare--Supplementary Medical Insurance Benefits	1832(a) (2)(B) (iii)	411(h)(4) (A)	786	--	--	109, 270-273
Medicare--Supplementary Medical Insurance Benefits	1832(a) (2)(B) (iii)	411(h)(7) (B)	787	--	--	111, 270-273
Medicare--Supplementary Medical Insurance Benefits	1832(a) (2)(B) (iv)	411(h)(4) (A)	786	--	--	109, 270-273
Medicare--Supplementary Medical Insurance Benefits	1832(a) (2)(B) (iv)	411(h)(7) (B)	787	--	--	111, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Supplementary Medical Insurance Benefits	1832(a) (2)(F) (i)	411(g)(2) (E)	783	--	--	106, 270-273
Medicare--Supplementary Medical Insurance Benefits	1832(a) (2)(F) (ii)	411(i)(4) (C)(vi)	789	--	--	113, 270-273
Medicare--Supplementary Medical Insurance Benefits	1832(a)	205(a)(2)	729	2/12, 51-53, 106	--	50, 204-206
Medicare--Supplementary Medical Insurance Benefits	1832(b)	104(d)(3)	689	1/53, 106	--	7, 146-149
Medicare--Fund Transfers	1833(a)	212(c)(2)	741	--	--	62, 157, 160, 166, 220-222
Medicare--Supplementary Medical Insurance Benefits	1833(a) (1)(D) (i)	411(i)(4) (C)(i)	789	--	--	113, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(a) (1)(F)	411(i)(4) (C)(ii)	789	--	--	113, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(a) (1)(F) Stricken	411(f)(12) (A)	781	--	--	104, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(a) (1)(G)	411(h)(4) (B)(iii)	786	--	--	109, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(a) (1)(G)	411(h)(7) (C)(ii)	787	--	--	111, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(a) (1)(H)	411(h)(4) (B)(iv) (I)	786	--	--	109, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(a) (1)(H)	411(h)(7) (C)(ii)	787	--	--	111, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Supplementary Medical Insurance Benefits	1833(a)(1)(H)	411(i)(3)	788	--	--	112, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(a)(1)	411(g)(1)(E)	782	--	--	106, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(a)(1)(I)	411(h)(4)(B)(iv)(I)	786	--	--	109, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(a)(1)(J)	411(f)(8)(C)	779	--	--	102, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(a)(1)(J)	411(h)(7)(C)(v)(I)	787	--	--	111, 270-273
Medicare--Coverage of Catastrophic Expenses (technical amendment)	1833(a)(1)(K)	202(b)(1)(A)	704	2/46-51	--	23, 173-199
Medicare--Supplementary Medical Insurance Benefits	1833(a)(1)(K)	411(h)(7)(C)(iii)	789	--	--	111, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(a)(1)(K)	411(h)(4)(B)(iv)(II)	786	--	--	110, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(a)(1)(K)	411(h)(4)(B)(iv)(III)	786	--	--	110, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(a)(1)(K)	411(h)(4)(B)(iv)(IV)	786	--	--	110, 270-273
Medicare--Coverage of Catastrophic Expenses (technical amendment)	1833(a)(1)(L)	202(b)(1)(B)	704	2/46-51	--	23, 173-199
Medicare--Supplementary Medical Insurance Benefits	1833(a)(1)(L)	411(h)(7)(C)(v)(II)	787	--	--	111, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Coverage of Catastrophic Expenses	1833(a)(1)(M) New	202(b)(1)(B)	704	2/5, 46-51	--	23, 173-199
Medicare--Coverage of Catastrophic Expenses	1833(a)(2)	202(b)(2)	704	2/46-51	--	23, 173-199
Medicare--In-Home Care for Certain Chronically Dependent Individuals	1833(a)(2)	205(c)(1)	730	2/12, 51-53, 107	--	51, 204-206
Medicare--Coverage of Catastrophic Expenses	1833(a)(2)(B)	203(c)(1)(A)	722	--	--	42, 199-204
Medicare--Coverage of Catastrophic Expenses	1833(a)(2)(D)	203(c)(1)(B)	722	--	--	42, 199-204
Medicare--Supplementary Medical Insurance Benefits	1833(a)(2)(D)(i)	411(i)(4)(C)(i)	789	--	--	110, 270-273
Medicare--Coverage of Catastrophic Expenses	1833(a)(2)(E)	203(c)(1)(C)	722	--	--	42, 199-204
Medicare--Coverage of Screening Mammography	1833(a)(2)(E)	204(d)(1)	729	--	--	49, 170-172
Medicare--Coverage of Home Intravenous Drug Therapy Services	1833(a)(2)(F) New	203(c)(1)(D)	722	--	--	42, 199-204
Medicare--In-Home Care for Certain Chronically Dependent Individuals	1833(a)(3)	205(c)(2)	730	2/13, 51-53, 108	--	51, 204-206
Medicare--In-Home Care for Certain Chronically Dependent Individuals	1833(a)	205(c)(3)	730	2/13, 51-53, 108	--	51, 204-206
Medicare--Coverage of Home Intravenous Drug Therapy Services	1833(b)	203(c)(1)(E)	722	--	--	42, 199-204
Medicare--Coverage of Catastrophic Expenses	1833(b)(1)	202(b)(3)(A)	704	2/5, 46-51, 108	--	23, 173-199
Medicare--Coverage of Catastrophic Expenses	1833(b)(2)	202(b)(3)(B)	704	2/5, 46-51, 108	--	23, 173-199

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Supplementary Medical Insurance Benefits	1833(b)(3) Stricken	411(f)(12)(A)	781	--	--	104, 270-273
Medicare--Supplementary Medical Insurance Benefits (technical amendment)	1833(b)(4) Redesignated as 1833(b)(3)	411(f)(12)(A)	781	--	--	104, 270-273
Medicare--Supplementary Medical Insurance Benefits (technical amendment)	1833(b)(5) Redesignated as 1833(b)(4)	411(f)(12)(A)	781	--	--	104, 270-273
Medicare--Limitation on Cost-Sharing	1833(c)	201(a)(1)(A)	700	1/21-23 2/44-46	7-9	19, 146-152
Medicare--Limitation on Cost-Sharing	1833(c)	201(a)(1)(C)	700	1/21-23 2/44-46	7-9	19, 146-152
Medicare--Limitation on Cost-Sharing	1833(c) Redesignated as 1833(d)(1)	201(a)(1)(D)	700	1/21-23 2/44-46	7-9	19, 146-152
Medicare--Limitation on Cost-Sharing	1833(c)(1) Redesignated as 1833(d)(1)(A)	201(a)(1)(B)	700	1/21-23 2/44-46	7-9	19, 146-152
Medicare--Limitation on Cost-Sharing	1833(c)(2) Redesignated as 1833(d)(1)(B)	201(a)(1)(B)	700	1/21-23 2/44-46	7-9	19, 146-152
Medicare--Limitation on Cost-Sharing	1833(c) New	201(a)(4)	700	1/21-23 2/44-46	7-9	19-20, 146-152
Medicare--Supplementary Medical Insurance Benefits	1833(c)	411(h)(1)(A)	785	1/21-23 2/44-46	--	109, 270-273
Medicare--Limitation on Cost-Sharing	1833(d) Redesignated as 1833(d)(2)	201(a)(2)	700	1/21-23 2/44-46	--	19, 146-152
Medicare--Supplementary Medical Insurance Benefits	1833(f)	411(g)(5)	785	--	--	109, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Supplementary Medical Insurance Benefits (technical amendment)	1833(f) Redesignated as 1833(o)	411(h)(3) (B)(ii)	786	--	--	109, 270-273
Medicare--Limitation on Cost-Sharing	1833(g)	201(a)(3)	700	1/21-23 2/44-46	--	19, 167-173
Medicare--Supplementary Medical Insurance Benefits	1833(h) (1)(D)	411(a)(3) (E)	784	--	--	107, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(h) (2)	411(g)(3) (E)	784	--	--	107, 270-273
Medicare--Supplementary Medical Insurance Benefits (technical amendment)	1833(h)(2) Redesignated as 1833(h) (2)(A)(i)	411(g)(3) (A)	783	--	--	107, 270-273
Medicare--Supplementary Medical Insurance Benefits (technical amendment)	1833(h) (2)(A)	411(g)(3) (A)	783	--	--	107, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(h) (2)(A) (ii) New	411(g)(3) (A)	783	--	--	107, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(h) (2)(A) (iii)	411(g)(3) (B)(ii)	784	--	--	107, 270-273
Medicare--Supplementary Medical Insurance Benefits (technical amendment)	1833(h) (2)(A)	411(g)(3) (B)(iii)	784	--	--	107, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(h) (2)(A) (iii)	411(g)(3) (C)	784	--	--	107, 270-273
Medicare--Supplementary Medical Insurance Benefits (technical amendment)	1833(h) (2)(B)	411(g)(3) (A)	783	--	--	107, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Supplementary Medical Insurance Benefits	1833(h) (4)(B) (ii)	411(g)(3) (D)	784	--	--	107, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(h) (5)(A)	411(i)(4) (C)(vi)	789	--	--	113, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(h) (5)(C)	411(i)(4) (C)(vi)	789	--	--	113, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(h) (5)(D)	411(i)(4) (B)(i)	789	--	--	112, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(h) (5)(D)	411(i)(4) (B)(ii)	789	--	--	112, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(i) (2)(A) (iii)	411(g)(2) (D)(i)	783	--	--	106, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(i) (2)(A) (iii)	411(g)(2) (D)(ii)	783	--	--	106, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(i) (4) Stricken	411(f)(12) (A)	781	--	--	104, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(i) (6) New	411(g)(2) (E)	783	--	--	106, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(~~i~~) (2)	411(f)(2) (D)	777	--	--	100, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(~~i~~) (5)(B) (ii)	411(i)(4) (C)(vi)	789	--	--	113, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(~~i~~) (5)(B) (ii)	411(i)(4) (C)(vi)	789	--	--	113, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Supplementary Medical Insurance Benefits (technical amendment)	1833(m) Redesignated as 1833(p)	411(h)(4) (C)(iii)	786	--	--	110, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(n) (1)(A)	411(g)(4) (C)(i)	785	--	--	108, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(n) (1)(B) (i)(II)	411(g)(4) (C)(ii)	785	--	--	108, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(n) (1)(B) (ii)(I)	411(g)(4) (C)(iii)	785	--	--	108, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(n) (1)(B) (ii)(II)	411(g)(4) (C)(iii)	785	--	--	108, 270-273
Medicare--Supplementary Medical Insurance Benefits	1833(p)	411(h)(4) (C)(iv)	786	--	--	110, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834 Heading	411(g)(1) (A)	781	--	--	105, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(a) (1)(C)	411(g)(1) (B)(i)	782	--	--	105, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(a) (2)(A)	411(g)(1) (B)(ii)	782	--	--	105, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(a) (2)(B) (i)	411(g)(1) (B)(iii)	782	--	--	105, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(a) (3)(A)	411(g)(1) (B)(iv)	782	--	--	105, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(a) (3)(B) (i)	411(g)(1) (B)(iii)	782	--	--	105, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Supplementary Medical Insurance Benefits	1834(a) (4)	411(g)(1) (B)(v)	782	--	--	105, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(a) (4)	411(g)(1) (B)(vi)	782	--	--	105, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(a) (4)	411(g)(1) (B)(vii)	782	--	--	105, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(a) (7)(A) (ii)	411(g)(1) (B)(vii)	782	--	--	105, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(a) (7)(A) (iii)	411(g)(1) (B)(vii)	782	--	--	105, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(a) (7)(A) (iii)(I)	411(g)(1) (B)(viii)	782	--	--	105, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(a) (7)(B) (i)	411(a)(3) (C)(ii)	768	--	--	91, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(a) (8)(A) (i)(I)	411(g)(1) (B)(iii)	782	--	--	105, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(a) (9)(A) (ii)(I)	411(g)(1) (B)(ix)	782	--	--	105, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(a) (9)(A) (ii)(II)	411(g)(1) (B)(x)	782	--	--	105, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(a) (9)(B) (i)	411(g)(1) (B)(xi)	782	--	--	105, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(a) (9)(C) (i)	411(g)(1) (B)(xii)	782	--	--	105, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Supplementary Medical Insurance Benefits	1834(a) (10)(B)	411(g)(1) (B)(xiii)	782	--	--	105, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(a) (10)(B) (i)	411(g)(1) (B)(xi)	782	--	--	105, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(a) (11)(A)	411(g)(1) (B)(vii)	782	--	--	105, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(a) (11)(A)	411(g)(1) (B)(xiv)	782	--	--	105, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(a) (12)	411(g)(1) (B)(xv)	782	--	--	106, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(a) (14)	411(g)(1) (B)(xvi)	782	--	--	106, 270-273
Medicare--Coverage of Screening Mammography	1834(b) (1)(B)	204(b)(1)	726	--	--	46, 170-172
Medicare--Supplementary Medical Insurance Benefits	1834(b) (4)(D)	411(f)(8) (D)(i)	779	--	--	103, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(b) (5)	411(f)(8) (D)(i)	779	--	--	103, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(b) (5)(C)	411(f)(8) (D)(ii)	779	--	--	103, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(b) (5)(C)	411(f)(8) (D)(iii)	779	--	--	103, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(b) (6)	411(f)(8) (D)(iv)	780	--	--	103, 270-273
Medicare--Supplementary Medical Insurance Benefits	1834(b) (6)	411(f)(8) (A)	779	--	--	102, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Supplementary Medical Insurance Benefits	1834(b) (6)(B)	411(f)(8) (D)(v)	780	--	--	103, 270-273
Medicare--Coverage of Catastrophic Expenses	1834(c) New	202(b)(4)	704	2/5-7, 46-51	--	23-33, 199
Medicare--Coverage of Home Intravenous Drug Therapy Services	1834(d) New	203(c)(1) (F)	722	--	--	43-44, 199-204
Medicare--Coverage of Screening Mammography	1834(e)	204(b)(2)	726	--	--	46-49, 170-172
Medicare--Coverage of Home Intravenous Drug Therapy Services (technical amendment)	1835(a) (2)(E)	203(d)(1) (A)	724	--	--	44, 199-204
Medicare--In-Home Care for Certain Chronically Dependent Individuals (technical amendment)	1835(a) (2)(F)	205(d)(1)	731	2/51-53	--	51, 204-206
Medicare--Coverage of Home Intravenous Drug Therapy Services	1835(a) (2)(F)	203(d)(1) (B)	724	--	--	44, 199-204
Medicare--Coverage of Home Intravenous Drug Therapy Services	1835(a) (2)(G) New	203(d)(1) (C)	724	--	--	45, 199-204
Medicare--In-Home Care for Certain Chronically Dependent Individuals	1835(a) (2)(G)	205(d)(2)	731	2/51-53	--	52, 204-206
Medicare--In-Home Care for Certain Chronically Dependent Individuals	1835(a) (2)(H) New	205(d)(3)	731	2/13, 51-53, 113	--	52, 204-206
Medicare--Adjustment in Premium	1839(a) (1)	211(c)(1) (A)	738	--	9-10	59, 208-220
Medicare--Adjustment in Premium	1839(a) (1)	211(c)(1) (B)	738	--	9-10	59, 208-220
Medicare--Adjustment in Premium	1839(a) (2)	211(c)(1) (C)	738	--	9-10	59, 208-220

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Adjustment in Premium	1839(a) (3)	211(c)(1) (D)	738	--	61	59, 208-220
Medicare--Adjustment in Premium	1839(a) (4)	211(c)(1) (A)	738	--	9-10	59, 208-220
Medicare--Adjustment in Premium	1839(a) (4)	211(c)(1) (B)	738	--	9-10	59, 208-220
Medicare--Adjustment in Premium	1839(b)	211(c)(1) (E)	738	1/54 2/21, 114	9-10	60, 208-220
Medicare--Adjustment in Premium	1839(e) (1)	211(c)(1) (F)	738	--	9-10	60, 208-220
Medicare--Adjustment in Premium	1839(f)	211(b)	738	--	9-10	59, 208-220
Medicare--Adjustment in Premium	1839(g) New	211(a)	733	1/27-30	9-10	54-59, 208-220
Medicare--Trust Fund Transfers	1840(i) New	212(b)(1)	740	--	10-12	61, 157, 160, 166, 220-222
Medicare--Trust Fund Transfers	1841(a)	212(b)(2)	740	--	10-12	62, 157, 160, 166, 220-222
Medicare--Trust Fund Transfers	1841(b)	212(c)(4)	741	--	10-12	62, 157, 160, 166, 220-222
Medicare--Trust Fund Transfers	1841A New	212(a)	739	--	10-12	60-61, 157, 160, 166, 220-222
Medicare--Creation of Catastrophic Coverage Account	1841B New	213(a)	741	--	10-12	63-64 222-225

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Supplementary Medical Insurance Benefits	1842(b) (2)	411(i)(2) (B)	788	--	--	112, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b) (2)(B) New	411(i)(2) (A)	788	--	--	112, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b) (2)	411(f)(1) (B)	776	--	--	99, 270-273
Medicare--Coverage of Catastrophic Expenses	1842(b) (2)	202(e)(3) (C)	717	2/46-51, 119	--	37, 173-199
Medicare--Supplementary Medical Insurance Benefits	1842(b) (3)	411(f)(4) (B)(ii)	778	--	--	101, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b) (3)	411(i)(4) (C)(vi)	789	--	--	113, 270-273
Medicare--Limitation on Cost-Sharing (technical amendment)	1842(b) (3)(G)	201(c)(1)	702	1/21-23 2/44-46	--	21, 167-173
Medicare--Limitation on Cost-Sharing (technical amendment)	1842(b) (3)(H)	201(c)(2)	702	1/21-23 2/44-46	--	21, 167-173
Medicare--Coverage of Catastrophic Expenses (technical amendment)	1842(b) (3)(H)	202(e)(2) (A)	716	2/46-51	--	36, 173-199
Medicare--Limitation on Cost-Sharing	1842(b) (3)(I) New	201(c)(3)	702	1/21-23 2/44-46	--	21, 167-173
Medicare--Coverage of Catastrophic Expenses	1842(b) (3)(J) New	202(e)(2) (B)	716	2/46-51	--	36, 173-199
Medicare--Coverage of Catastrophic Expenses	1842(b) (3)(K) New	202(e)(2) (B)	716	2/46-51	--	36, 173-199
Medicare--Supplementary Medical Insurance Benefits	1842(b) (3)	411(f)(11) (A)	781	--	--	104, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Supplementary Medical Insurance Benefits	1842(b) (4)(A) (iv)	411(f)(2) (F)(i)	777	--	--	100-101 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b) (4)(A) (iv)(II)	411(f)(2) (E)	777	--	--	100, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b) (4)(A) (vi)	411(f)(3) (B)(iii)	778	--	--	101, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b) (4)(A) (vi)	411(f)(3) (B)(ii)	778	--	--	101, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b) (4)(A) (vi)	411(f)(3) (B)(i)	778	--	--	101, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b) (4)(A) (vii)	411(f)(2) (D)	777	--	--	100, 270-273
Medicare--Supplementary Medical Insurance Benefits (technical amendment)	1842(b) (4)(E)	411(f)(2) (C)	777	--	--	100, 270-273
Medicare--Supplementary Medical Insurance Benefits (technical amendment)	1842(b) (4)(E) (i)	411(f)(2) (C)	777	--	--	100, 270-273
Medicare--Supplementary Medical Insurance Benefits (technical amendment)	1842(b) (4)(E) (ii)	411(f)(2) (C)	777	--	--	100, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b) (4)(F) Redesignated as 1842(b) (4)(E)	411(f)(2) (C)	777	--	--	100, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b) (4)(F) (ii)(I)	411(f)(2) (B)	777	--	--	100, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Supplementary Medical Insurance Benefits	1842(b)(4)(F)(iii)(I)	411(f)(2)(A)(i)	777	--	--	100, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b)(4)(F)(iii)(II)	411(f)(2)(A)(ii)	777	--	--	100, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b)(4)(G)	411(f)(6)(B)(ii)	779	--	--	102, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b)(4)(G)	411(f)(6)(B)(i)	779	--	--	102, 270-273
Medicare--Supplementary Medical Insurance Benefits (technical amendment)	1842(b)(4)(G) Redesignated as 1842(b)(4)(F)	411(f)(2)(C)	777	--	--	100, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b)(5)(A)	411(i)(2)(A)	788	--	--	112, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b)(5)(B)	411(i)(2)(A)	788	--	--	112, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b)(7)(B)(iii)	411(i)(4)(C)(vi)	789	--	--	113, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b)(10)(A)(i)	411(f)(4)(A)(i)(I)	778	--	--	101, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b)(10)(A)(i)	411(f)(4)(A)(i)(II)	778	--	--	101, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b)(10)(A)(i)	411(f)(4)(A)(i)(III)	778	--	--	101, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b)(10)(A)(iii)	411(f)(4)(A)(ii)	778	--	--	101, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Supplementary Medical Insurance Benefits	1842(b)(10)(B)	411(f)(4)(A)(iii)	778	--	--	101, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b)(10)(D)	411(f)(4)(A)(iv)	778	--	--	101, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b)(11)(B)(i)	411(f)(4)(B)(i)	778	--	--	101, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b)(11)(C)(i)	411(f)(5)(A)	778	--	--	102, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b)(11)(C)(ii)	411(g)(2)(A)(i)	783	--	--	106, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b)(11)(C)(ii)	411(g)(2)(A)(ii)	783	--	--	106, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b)(12)(C)	411(i)(4)(C)(vi)	789	--	--	113, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(b)(12)(C)	411(i)(4)(C)(vi)	789	--	--	113, 270-273
Medicare--Supplementary Medical Insurance Benefits (technical amendment)	1842(b)(14) Redesignated as 1842(b)(13)	411(f)(7)(A)	779	--	--	102, 270-273
Medicare--Coverage of Catastrophic Expenses (technical amendment)	1842(c)(1)(A) Redesignated as 1842(c)(1)(A)(i)	202(e)(3)(A)(i)	716	2/46-51	--	36, 173-199
Medicare--Coverage of Catastrophic Expenses	1842(c)(1)(A)(i)	202(e)(3)(A)(ii)	716	2/46-51	--	36, 173-199
Medicare--Coverage of Catastrophic Expenses	1842(c)(1)(A)(ii) New	202(e)(3)(A)(iii)	716	2/46-51	--	36-37, 173-199

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Coverage of Catastrophic Expenses	1842(c) (2)(A)	202(e)(5) (A)	717	2/46-51	--	37, 173-199
Medicare--Coverage of Catastrophic Expenses	1842(c) (3)(A)	202(e)(5) (A)	717	2/46-51	--	37, 173-199
Medicare--Coverage of Catastrophic Expenses	1842(c)(4) New	202(e)(5) (B)	717	2/46-51	--	37, 173-199
Medicare--Coverage of Catastrophic Expenses (technical amendment)	1842(f) (1)	202(e)(1) (A)	716	2/46-51	--	36, 173-199
Medicare--Coverage of Catastrophic Expenses (technical amendment)	1842(f) (2)	202(e)(1) (B)	716	2/46-51	--	36, 173-199
Medicare--Coverage of Catastrophic Expenses	1842(f)(3) New	202(e)(1) (C)	716	2/46-51	--	36, 173-199
Medicare--Coverage of Catastrophic Expenses	1842(h) (1)	202(e)(1) (A)	714	2/46-51	--	33, 173-199
Medicare--Coverage of Catastrophic Expenses	1842(h) (2)	202(e)(4) (A)	717	2/46-51	--	37, 173-199
Medicare--Supplementary Medical Insurance Benefits	1842(h) (3)(B)	411(i)(1) (A)(i) (I)	787	--	--	111, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(h) (3)(B)	411(i)(1) (A)(i) (II)	788	--	--	111, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(h) (3)(B)	411(i)(1) (A)(ii)	788	--	--	111, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(h) (3)(B)	411(i)(1) (A)(iii) (I)	788	--	--	111, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(h) (3)(B)	411(i)(1) (A)(iii) (II)	788	--	--	111, 270-273
Medicare--Coverage of Catastrophic Expenses	1842(h) (4)	202(c)(1) (B)	714	2/46-51	--	33-34 173-199

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Distribution of Information Describing Participating Physician Program	1842(h) (5)	223(b)(1)	747	2/56-57	13-14	69, 228-230
Medicare--Distribution of Information Describing Participating Physician Program	1842(h) (5)	223(b)(2)	747	2/56-57	13-14	69, 228-230
Medicare--Distribution of Information Describing Participating Physician Program (technical amendment)	1842(h)(5) Redesignated as 1842(h) (5)(A)	223(b)(3)	747	2/56-57	13-14	69, 228-230
Medicare--Distribution of Information Describing Participating Physician Program	1842(h) (5)(B) New	223(b)(4)	747	2/56-57	13-14	69, 228-230
Medicare--Supplementary Medical Insurance Benefits	1842(h) (7)	411(f)(2) (C)	777	--	--	100, 270-273
Medicare--Revision of Explanation of Benefits	1842(h) (7)(A)	223(c)(1) (A)	747	2/56-57	13-14	69, 228-230
Medicare--Revision of Explanation of Benefits	1842(h) (7)(A)	223(c)(1) (B)	747	2/56-57	13-14	69, 228-230
Medicare--Revision of Explanation of Benefits (technical amendment)	1842(h) (7)(B)	223(c)(2)	747	2/56-57	13-14	69, 228-230
Medicare--Revision of Explanation of Benefits	1842(h) (7)(C) New	223(c)(3)	748	2/56-57	13-14	69, 228-230
Medicare--Supplementary Medical Insurance Benefits	1842(h) (8)	411(f)(2) (C)	777	--	--	100, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(h) (8)	411(f)(2) (C)	777	--	--	100, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(h) (8)	411(f)(2) (C)	777	--	--	100, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Supplementary Medical Insurance Benefits	1842(i) (2)	411(f)(2) (C)	777	--	--	100, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(i) (3)	411(f)(2) (C)	777	--	--	100, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(i) (4)	411(f)(2) (C)	777	--	--	100, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(j) (1)(C) (i)(I)	411(f)(2) (F)(ii)	778	--	--	101, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(j) (1)(C) (i)(II)	411(f)(2) (F)(ii)	778	--	--	101, 270-273
Medicare--Supplementary Medical Insurance Benefits (technical amendment)	1842(j)(1) (C)(vii) Redesignated as 1842(j)(1) (C)(viii)	411(f)(1) (A)(ii)	776	--	--	99, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(j)(1) (C)(ix) New	411(f)(7) (B)	779	--	--	102, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(j) (1)(D) (ii)(IV)	411(f)(5) (B)	779	--	--	102, 270-273
Medicare--Supplementary Medical Insurance Benefits (technical amendment)	1842(j)(1) (D)(ii)(IV) Redesignated as 1842(j) (1)(D)(ii) (V)	411(g)(2) (B)	783	--	--	106, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(j) (1)(D) (ii)(V)	411(g)(2) (B)	783	--	--	106, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(j) (1)(D) (iii)(II)	411(g)(2) (C)	783	--	--	106, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Supplementary Medical Insurance Benefits	1842(j)(1)(D)(iv)	411(f)(4)(C)	778	--	--	101, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(j)(2)	411(i)(4)(C)(vi)	789	--	--	113, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(j)(2)(B)	411(i)(4)(C)(vi)	789	--	--	113, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(j)(2)(B)	411(i)(4)(C)(vi)	789	--	--	113, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(j)(2)(B)	411(i)(4)(C)(vi)	789	--	--	113, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(l)(1)(C)(i)	411(i)(4)(C)(vi)	789	--	--	114, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(n)(1)	411(f)(9)(A)(i)	780	--	--	103, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(n)(1)	411(f)(9)(A)(ii)	780	--	--	103, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(n)(1)	411(f)(9)(A)(iii)	780	--	--	103, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(n)(1)	411(f)(9)(A)(iv)	780	--	--	103, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(n)(1)(A)	411(a)(3)(C)(i)	768	--	--	91, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(n)(1)(A)	411(f)(9)(B)	780	--	--	103, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Supplementary Medical Insurance Benefits	1842(n) (2)(A)	411(f)(9) (C)	780	--	--	103, 270-273
Medicare--Supplementary Medical Insurance Benefits	1842(n) (3)	411(f)(9) (D)	780	--	--	103, 270-273
Medicare--Coverage of Catastrophic Expenses	1842(o) New	202(c)(1) (C)	714	2/46-51	14	34-35, 173-199
Medicare--Coverage of Catastrophic Expenses	1842(p) New	202(g)	718	2/46-51	14	38, 173-199
Medicare--Medicaid Buy-in of Premiums and Cost-Sharing for Indigent Beneficiaries	1843(a)	301(e)(1)	749	1/58 2/18, 57-62, 122	--	71, 253-257
Medicare--Medicaid Buy-in of Premiums and Cost-Sharing for Indigent Beneficiaries	1843(g) (1)	301(e)(1)	749	1/58 2/18, 57-62, 122	--	71, 253-257
Medicare--Medicaid Buy-in of Premiums and Cost-Sharing for Indigent Beneficiaries	1843(h) (1)	301(e)(1)	749	1/58 2/18, 57-62, 122	--	71, 253-257
Medicare--Adjustment in Premium	1844(a)	211(c)(2)	738	2/11, 123	--	60, 208-220
Medicare--Supplementary Medical Insurance Benefits	1845(f) (1)	411(i)(4) (A)(i)	788	--	--	112, 270-273
Medicare--Supplementary Medical Insurance Benefits	1845(f) (2)	411(i)(4) (A)(ii)	789	--	--	112, 270-273
Medicare--Coverage of Home Intravenous Drug Therapy Services	1846 Heading	203(e)(4) (A)	725	--	--	45, 199-204
Medicare--Coverge of Home Intravenous Drug Therapy Services	1846(a)	203(e)(4) (B)	725	--	--	45, 199-204

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Supplementary Medical Insurance Benefits	1846(a)	411(g)(3) (G)(i)(I)	784	--	--	107, 270-273
Medicare--Supplementary Medical Insurance Benefits	1846(a)	411(g)(3) (G)(i)(II)	784	--	--	108, 270-273
Medicare--Supplementary Medical Insurance Benefits	1846(a)	411(g)(3) (G)(i)(III)	784	--	--	108, 270-273
Medicare--Supplementary Medical Insurance Benefits	1846(b) (1)(A)	411(g)(3) (G)(ii)	784	--	--	108, 270-273
Medicare--Coverage of Home Intravenous Drug Therapy Services	1846(b) (2)(A) (iv)	203(e)(4) (C)	725	--	--	45, 199-204
Medicare--Supplementary Medical Insurance Benefits	1846(b) (2)(A) (iv)	411(g)(3) (G)(ii)	784	--	--	108, 270-273
Medicare--Supplementary Medical Insurance Benefits	1846(b) (2)(A) (ii)	411(g)(3) (G)(iii)	784	--	--	108, 270-273
Medicare--Supplementary Medical Insurance Benefits	1846(b) (2)(A)	411(g)(3) (G)(iv)	784	--	--	108, 270-273
Medicare--Supplementary Medical Insurance Benefits	1846(b) (2)(A) (iii)	411(g)(3) (G)(v)	784	--	--	108, 270-273
Medicare--Supplementary Medical Insurance Benefits	1846(b) (2)(A) (iv)	411(g)(3) (G)(vi)	784	--	--	108, 270-273
Medicare--Supplementary Medical Insurance Benefits	1846(b) (3)	411(g)(3) (G)(vii)	785	--	--	108, 270-273
Medicare--Prescription Drug Payment Review Commission	1847 New	202(j)	719	2/46-51	14	39-40, 173-199
Medicare--Definitions--Spell of Illness	1861(a) Stricken	104(d)(4) (A)	689	1/59 2/123	--	7, 146-149

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Definitions--Spell of Illness	1861(a)(2)	411(k)(1)(B)(ii)	801	--	--	125, 270-273
Medicare--Definitions--Hospital	1861(e)	104(d)(4)(B)(i)	689	2/123	--	8, 146-149
Medicare--Definitions--Hospital	1861(e)	104(d)(4)(B)(iv)	689	1/59	--	7, 146-149
Medicare--Definitions--Hospital	1861(e)	104(d)(4)(B)(ii)	689	1/59 2/124	--	8, 146-149
Medicare--Definitions--Hospital	1861(e)	104(d)(4)(B)(iii)	689	1/60 2/124	--	8, 146-149
Medicare--Definitions--Post-Hospital Extended Care Services	1861(i) Stricken	104(d)(4)(C)	689	1/60-61 2/124-125	--	8, 146-149
Medicare--Definitions--Home Health Services	1861(m)	206(a)	731	1/23-24, 62 2/15, 53-54, 126	12-13	52, 206-207
Medicare--Definitions--Durable Medical Equipment	1861(n)	411(d)(1)(B)(i)	773	--	--	96, 270-273
Medicare--Definitions--Durable Medical Equipment	1861(n)	411(k)(1)(B)(iii)	801	--	--	125, 270-273
Medicare--Definitions--Medical and Other Health Services	1861(s)(2)(H)(ii)	411(h)(5)(A)	787	--	--	110, 270-273
Medicare--Description of Covered Outpatient Drugs	1861(s)(2)(J)	202(a)(1)	702	2/46-51, 126-127	14	21, 173-199
Medicare--Definitions--Medical and Other Health Services	1861(s)(2)(K)	411(h)(6)	787	--	--	110, 270-273
Medicare--Definitions--Medical and Other Health Services	1861(s)(10)(A)	411(h)(2)	786	--	--	109, 270-273
Medicare--Definitions--Medical and Other Health Services (technical amendment)	1861(s)(11)	204(a)(1)(B)	725	--	--	46, 170-172

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Definitions--Medical and Other Health Services	1861(s)	411(g)(3)(H)	785	--	--	108, 270-273
Medicare--Definitions--Medical and Other Health Services (technical amendment)	1861(s)(12)	204(a)(1)(C)	725	--	--	46, 270-273
Medicare--Definitions--Medical and Other Health Services	1861(s)(12)	411(h)(3)(A)	786	--	--	109, 270-273
Medicare--Definitions--Medical and Other Health Services (technical amendment)	1861(s)(13) Redesignated as 1861(s)(14)	204(a)(1)(D)	725	--	--	46, 170-172
Medicare--Definitions--Medical and Other Health Services	1861(s)(13) New	204(a)(1)(A)	725	--	--	46, 170-172
Medicare--Definitions--Medical and Other Health Services (technical amendment)	1861(s)(14) Redesignated as 1861(s)(15)	204(a)(1)(A)	725	--	--	46, 170-172
Medicare--Definitions--Covered Outpatient Drugs	1861(t)	202(a)(2)(A)	702	2/46-51, 127	14	21, 167-173
Medicare--Definitions--Covered Outpatient Drugs (technical amendment)	1861(t) Redesignated as 1861(t)(1)	202(a)(2)(B)	702	2/46-51, 127	14	21, 167-173
Medicare--Definitions--Covered Outpatient Drugs	1861(t)(2) New	202(a)(2)(C)	702	2/46-51, 127	14	21-22, 167-173
Medicare--Definitions--Covered Outpatient Drugs	1861(t)(3) New	202(a)(2)(C)	702	2/46-51	14	22-23, 167-173
Medicare--Definitions--Covered Outpatient Drugs	1861(t)(4)	202(a)(2)(C)	702	2/46-51	14	23, 167-173
Medicare--Definitions--Providers of Services	1861(u)	203(e)(1)	725	--	--	45, 199-204
Medicare--Definitions--Reasonable Cost	1861(v)(1)(G)(i)	104(d)(4)(D)	689	1/62-63 2/127	68-69	8, 146-149

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Definitions--Reasonable Cost	1861(v)(1)(L)(iii)	411(d)(5)(A)(i)	774	--	--	97, 270-273
Medicare--Definitions--Reasonable Cost	1861(v)(1)(L)(iii)	411(d)(5)(A)(ii)	774	--	--	97, 270-273
Medicare--Definitions--Reasonable Cost	1861(v)(2)(A)	104(d)(4)(D)	689	2/128	--	8, 146-149
Medicare--Definitions--Reasonable Cost	1861(v)(3)	104(d)(4)(D)	689	2/128	--	8, 146-149
Medicare--Definitions--Extended Care in Christian Science Skilled Nursing Facilities	1861(y) Heading	104(d)(4)(E)(i)	689	1/64 2/129	--	8, 146-149
Medicare--Definitions--Extended Care in Christian Science Skilled Nursing Facilities	1861(y)	104(d)(4)(E)(i)	689	1/64 2/129	--	8, 146-149
Medicare--Definitions--Extended Care in Christian Science Skilled Nursing Facilities	1861(y)(1)	104(d)(4)(E)(ii)	689	1/64 2/129	--	8, 146-149
Medicare--Definitions--Extended Care in Christian Science Skilled Nursing Facilities	1861(y)(2)	104(d)(4)(E)(iii)	689	1/64 2/129	--	8, 146-149
Medicare--Definitions--Extended Care in Christian Science Skilled Nursing Facilities	1861(y)(2)(A)(i)	104(d)(4)(E)(iv)	689	2/129	--	8, 146-149
Medicare--Definitions--Extended Care in Christian Science Skilled Nursing Facilities	1861(y)(3)	104(d)(4)(E)(iii)	689	1/64 2/129	--	8, 146-149
Medicare--Definitions--Extended Care in Christian Science Skilled Nursing Facilities	1861(y)(3)	104(d)(4)(E)(v)	689	1/64 2/129	--	8, 146-149

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Definitions--Extended Care in Christian Science Skilled Nursing Facilities	1861(y)(4) Stricken	104(d)(4)(E)(vi)	689	1/64 2/129	--	8, 146-149
Medicare--Definitions--Services of a Certified Registered Nurse Anesthetist	1861(bb)(2)	411(i)(3)	788	--	--	112, 270-273
Medicare--Definitions--Partial Hospitalization Services	1861(ff) Heading	411(h)(1)(B)(i)	785	--	--	109, 270-273
Medicare--Definitions--Certified Nurse-Midwife Services (technical amendment)	1861(ff) Redesignated as 1861(gg)	411(h)(4)(D)(i)	787	--	--	110, 270-273
Medicare--Definitions	1861(ff)(3)	411(h)(1)(B)(ii)	786	--	--	109, 270-273
Medicare--Definitions--Clinical Social Worker (technical amendment)	1861(ff) Redesignated as 1861(hh)	411(h)(5)(B)	787	--	--	110, 270-273
Medicare--Definitions	1861(gg)(1)	411(h)(4)(D)(ii)	787	--	--	110, 270-273
Medicare--Definitions--Qualified Psychologist Services (technical amendment)	1861(gg) Redesignated as 1861(ii)	411(h)(7)(E)	787	--	--	111, 270-273
Medicare--Definitions--Home Intravenous Drug Therapy Provider	1861(jj) New	203(b)	721	--	--	41-42, 199-204
Medicare--Definitions--Screening Mammography	1861(kk) New	204(a)(2)	725	--	--	46, 170-172
Medicare--Definitions--In-Home Care; Chronically Dependent Individual	1861(ll)	205(b)	730	2/12, 51-53, 130	--	50-51, 204-206
Medicare--Exclusions from Coverage--Screening Mammography	1862(a)(1)(A)	204(d)(2)(A)(i)	729	2/14, 130	--	49, 170-172

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Exclusions from Coverage--Screening Mammography (technical amendment)	1862(a)(1)(D)	204(d)(2)(A)(ii)	729	--	--	49, 170-172
Medicare--Exclusions from Coverage (technical amendment)	1862(a)(1)(E)	204(d)(2)(A)(iii)	729	--	--	49, 170-172
Medicare--Exclusions from Coverage (technical amendment)	1862(a)(1)(E)	205(e)(1)(A)(i)	731	2/51-53	--	52, 204-206
Medicare--Exclusions from Coverage	1862(a)(1)(F) New	204(d)(2)(A)(iv)	729	--	--	49, 170-172
Medicare--Exclusions from Coverage (technical amendment)	1862(a)(1)(F)	205(e)(1)(A)(ii)	731	2/51-53	--	52, 204-206
Medicare--Exclusions from Coverage	1862(a)(1)(G) New	205(e)(1)(A)(iv) (sic)	731	2/14, 51-53, 131	--	52, 204-206
Medicare--Exclusions from Coverage	1862(a)(6)	205(e)(1)(3)	731	2/51-53, 131	--	52, 204-206
Medicare--Exclusions from Coverage	1862(a)(7)	204(d)(2)(B)	729	--	--	49, 170-172
Medicare--Exclusions from Coverage	1862(a)(15)	411(f)(4)(D)(i)	778	--	--	101, 270-273
Medicare--Exclusions from Coverage (technical amendment)	1862(c) Redesignated as 1862(c)(1)	202(d)(5)	716	2/46-51	14	35, 173-199
Medicare--Exclusions from Coverage (technical amendment)	1862(c)(1) Redesignated as 1862(c)(1)(A)	202(d)(4)	716	2/46-51	14	35, 173-199
Medicare--Exclusions from Coverage (technical amendment)	1862(c)(1)(A) Redesignated as 1862(c)(1)(A)(i)	202(d)(1)	715	2/46-51	14	35, 173-199

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Exclusions from Coverage (technical amendment)	1862(c)(1)(B) Redesignated as 1862(c)(1)(A)(ii)	202(d)(1)	715	2/46-51	14	35, 173-199
Medicare--Exclusions from Coverage (technical amendment)	1862(c)(1)(C) Redesignated as 1862(c)(1)(A)(iii)	202(d)(1)	715	2/46-51	14	35, 173-199
Medicare--Exclusions from Coverage (technical amendment)	1862(c)(1)(D) Redesignated as 1862(c)(1)(A)(iv)	202(d)(1)	715	2/46-51	14	35, 173-199
Medicare--Exclusions from Coverage (conforming amendment)	1862(c)(2)(A)	202(d)(2)	715	2/46-51	14	35, 173-199
Medicare--Exclusions from Coverage (technical amendment)	1862(c)(2)(A) Redesignated as 1862(c)(1)(B)(i)	202(d)(3)	715	2/46-51	14	35, 173-199
Medicare--Exclusions from Coverage (technical amendment)	1862(c)(2) Redesignated as 1862(c)(1)(B)	202(d)(4)	716	2/46-51	14	35, 173-199
Medicare--Exclusions from Coverage (technical amendment)	1862(c)(2)(B) Redesignated as 1862(c)(1)(B)(ii)	202(d)(3)	715	2/46-51	14	35, 173-199
Medicare--Exclusions from Coverage	1862(c)(2) New	202(d)(6)	716	2/46-51	14	36, 173-199
Medicare--Exclusions from Coverage	1862(e)	411(i)(4)(D)(i)(I)	790	--	--	114, 270-273
Medicare--Exclusions from Coverage	1862(e)	411(i)(4)(D)(i)(III)	790	--	--	114, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Exclusions from Coverage	1862(e) (1)	411(i)(4) (D)(i)(II)	790	--	--	114, 270-273
Medicare--Exclusions from Coverage	1862(e) (2)	411(i)(4) (D)(i)(II)	790	--	--	114, 270-273
Medicare--Coverage of Home Intravenous Drug Therapy Services	1863	203(e)(2)	725	--	--	45, 199-204
Medicare--Coverage of Screening Mammography	1863	204(c)(1)	728	--	--	49, 170-172
Medicare--Determinations of Compliance by Providers of Services (conforming amendment)	1864(a)	204(d)(3)	729	--	--	50, 170-172
Medicare--Determinations of Compliance by Providers of Services	1864(a)	411(l)(6) (B)	804	--	--	129, 270-273
Medicare--Determinations of Compliance by Providers of Services	1864(a)	203(e)(3) (A)	725	--	--	45, 199-204
Medicare--Determinations of Compliance by Providers of Services	1864(a)	204(c)(2)	728	--	--	49, 170-172
Medicare--Determinations of Compliance by Providers of Services	1864(a)	203(e)(3) (B)	725	--	--	45, 199-204
Medicare--Determinations of Compliance by Providers of Services	1864(a)	411(d)(4) (A)(i)	774	--	--	97, 270-273
Medicare--Determinations of Compliance by Providers of Services	1864(a)	411(d)(4) (A)(ii)(I)	774	--	--	97, 270-273
Medicare--Determinations of Compliance by Providers of Services	1864(a)	411(d)(4) (A)(ii)(II)	774	--	--	97, 270-273
Medicare--Effect of Accreditation	1865(a)	204(c)(3)	728	--	--	49, 170-172

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Effect of Accreditation (conforming amendment)	1865(a)	204(d)(3)	729	--	--	50, 170-172
Medicare--Effect of Accreditation	1865(a)	411(d)(4) (B)(ii)	774	--	--	97, 270-273
Medicare--Agreements with Providers of Services	1866(a) (1)(D)	411(c)(2) (A)(i)	772	--	--	95, 270-273
Medicare--Agreements with Providers of Services	1866(a) (2)(A)	202(h)(1) (A)	718	2/46-51	14	38, 173-199
Medicare--Agreements with Providers of Services	1866(a) (2)(A)	202(h)(1) (B)	718	2/46-51	--	38, 173-199
Medicare--Agreements with Providers of Services	1866(a) (2)(A)	201(d)	702	2/44-46	--	21, 167-173
Medicare--Agreements with Providers of Services	1866(a) (2)(A)	411(g)(1) (D)	782	--	--	106, 270-273
Medicare--Agreements with Providers of Services	1866(a) (2)(A)	201(b)	702	1/65 2/44-46, 131	73	21, 167-173
Medicare--Agreements with Providers of Services	1866(d)	104(d)(5)	689	1/66 2/132	--	8, 146-149
Medicare--Agreements with Providers of Services	1866(g)	411(i)(4) (C)(vi)	789	--	--	114, 270-273
Medicare--Agreements with Providers of Services	1866(g)	411(i)(4) (C)(vi)	789	--	--	114, 270-273
Medicare--Emergency Medical Conditions and Women in Active Labor	1867(d) (1)	411(b)(8) (A)(i)	772	--	--	94, 270-273
Medicare--Emergency Medical Conditions and Women in Active Labor	1867(d) (2)	411(b)(8) (A)(i)	772	--	--	94, 270-273
Medicare--Emergency Medical Conditions and Women in Active Labor	1867(d)	411(b)(8) (A)(i)	772	--	--	94, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Emergency Medical Conditions and Women in Active Labor	1867(d)(2)(A)	411(b)(8)(A)(i)	772	--	--	94, 270-273
Medicare--Emergency Medical Conditions and Women in Active Labor	1867(d)(2)(B)	411(b)(8)(A)(i)	772	--	--	94, 270-273
Medicare--Emergency Medical Conditions and Women in Active Labor	1867(d)(2) Second Sentence Redesignated as Subparagraph (C)	411(b)(8)(A)(i)	772	--	--	94, 270-273
Medicare--Emergency Medical Conditions and Women in Active Labor	1867(d)(2)(A) New	411(b)(8)(A)(i)	772	--	--	94, 270-273
Medicare--Emergency Medical Conditions and Women in Active Labor	1867(d)(2)(B) New	411(b)(8)(A)(i)	772	--	--	94, 270-273
Medicare--Overpayments; Settlement of Claims for Benefits of Deceased Individuals	1870 Heading	411(e)(3)	775	--	--	99, 270-273
Medicare--Overpayments; Settlement of Claims for Benefits of Deceased Individuals	1870(f)	411(j)(4)(B)	791	--	--	115, 270-273
Medicare--Payments to Health Maintenance Organizations	1876(a)(5)	211(c)(3)(A)	738	--	--	60, 208-220
Medicare--Payments to Health Maintenance Organizations	1876(a)(5)	211(c)(3)(B)	739	--	--	60, 208-220
Medicare--Payments to Health Maintenance Organizations (technical amendment)	1876(c)(3)(F)	411(c)(1)	772	--	--	95, 270-273
Medicare--Payments to Health Maintenance Organizations	1876(e)(1)	202(f)(1)	717	2/46-51	14	38, 173-199

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Payments to Health Maintenance Organizations	1876(f)(3)(A)	411(c)(5)(A)	773	--	--	96, 270-273
Medicare--Payments to Health Maintenance Organizations	1876(f)(3)(A)	411(c)(5)(B)	773	--	--	96, 270-273
Medicare--Payments to Health Maintenance Organizations	1876(g)(3)(A)	202(f)(2)	718	2/46-51	14	38, 173-199
Medicare--Payments to Health Maintenance Organizations	1876(g)(5)	411(c)(3)	773	--	--	95, 270-273
Medicare--Payments to Health Maintenance Organizations	1876(i)(6)(A)	411(c)(4)(A)	773	--	--	96, 270-273
Medicare--Payments to Health Maintenance Organizations	1876(i)(6)(B)(i)	224	748	--	--	70, 247-248
Medicare--Payments to Health Maintenance Organizations	1876(i)(6)(B)	411(c)(4)(B)	773	--	--	96, 270-273
Medicare--Payments to Health Maintenance Organizations	1876(i)(7)(A)	411(e)(3)	775	--	--	99, 270-273
Medicare--Payments to Health Maintenance Organizations	1876(i)(7)(A)	411(e)(3)	775	--	--	99, 270-273
Medicare--Payments to Health Maintenance Organizations	1876(i)(7)(A)	411(e)(3)	775	--	--	99. 270-273
Medicare--Payments to Health Maintenance Organizations	1876(i)(7)(B)	411(e)(3)	775	--	--	99, 270-273
Medicare--Supplemental Health Insurance Policies	1882(a)	221(d)(1)	743	1/30-32 2/63	15-17, 74	65, 234-240
Medicare--Supplemental Health Insurance Policies	1882(b)	221(d)(2)	743	1/30-32 2/63	15-17, 75	65, 234-240

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Supplemental Health Insurance Policies	1882(b) (1)(B)	221(a)(1)	743	1/30-32 2/63	15-17	64, 234-240
Medicare--Supplemental Health Insurance Policies	1882(b) (1)(C)	221(b)(1)	743	1/30-32 2/63	15-17, 75	64, 234-240
Medicare--Supplemental Health Insurance Policies (technical amendment)	1882(b) (1)(C) Redesignated as 1882(b) (1)(D)	221(b)(2)	743	1/30-32 2/63	15-17, 75	64, 234-240
Medicare--Supplemental Health Insurance Policies	1882(b) (1)(C) New	221(b)(3)	743	1/30-32 2/63	15-17, 75	64, 234-240
Medicare--Supplemental Health Insurance Policies (technical amendment)	1882(b) (1)(D) Redesignated as 1882(b) (1)(E)	221(b)(2)	743	1/30-32 2/63	15-17, 75	64, 234-240
Medicare--Supplemental Health Insurance Policies	1882(b) (2)(A)	221(f)	746	1/30-32 2/63	15-17	68, 234-240
Medicare--Supplemental Health Insurance Policies	1882(b)(3) New	221(e)	746	1/30-32, 66 2/63, 133	15-17	67, 234-240
Medicare--Supplemental Health Insurance Policies	1882(c)	411(i)(1) (B)	788	1/66	--	111, 270-273
Medicare--Supplemental Health Insurance Policies (technical amendment)	1882(c) (2)	221(a)(2) (A)	743	1/30-32 2/63	15-17, 76	64, 234-240
Medicare--Supplemental Health Insurance Policies (technical amendment)	1882(c) (3)	221(a)(2) (B)	743	1/30-32 2/63	15-17	64, 234-240
Medicare--Supplemental Health Insurance Policies	1882(c) (3)(A)	411(i)(1) (C)(i)	788	--	--	112, 270-273
Medicare--Supplemental Health Insurance Policies	1882(c) (3)(B)(i)	411(i)(1) (C)(ii)	788	--	--	112, 270-273
Medicare--Supplemental Health Insurance Policies	1882(c) (3)(B)(ii)	411(i)(1) (C)(iii)	788	--	--	112, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Supplemental Health Insurance Policies	1882(c)(4) New	221(a)(2) (C)	743	1/30-32 2/63	15-17, 76	64, 234-240
Medicare--Supplemental Health Insurance Policies	1882(d) (1)	428(b)(1)	817	--	--	142, 239-240
Medicare--Supplemental Health Insurance Policies	1882(d) (2)	428(b)(1)	817	--	--	142, 239-240
Medicare--Supplemental Health Insurance Policies	1882(d) (3)(A)	428(b)(1)	817	--	--	142, 239-240
Medicare--Supplemental Health Insurance Policies	1882(d) (4)(A)	428(b)(1)	817	--	--	142, 239-240
Medicare--Supplemental Health Insurance Policies	1882(d)(5) New	428(b)(2)	817	--	--	142, 239-240
Medicare--Supplemental Health Insurance Policies (technical amendment)	1882(e) Redesignated as 1882(e) (1)	221(c)(1)	743	1/30-32 2/63	15-17, 76	64, 234-240
Medicare--Supplemental Health Insurance Policies	1882(e)(2) New	221(c)(2)	743	1/30-32 2/63	15-17, 76	65, 234-240
Medicare--Supplemental Health Insurance Policies	1882(e)(3) New	221(c)(2)	743	1/30-32 2/63	15-17, 76	65, 234-240
Medicare--Supplemental Health Insurance Policies	1882(k) New	221(d)(3)	743	1/30-32 2/63	15-17, 76	65-66, 234-240
Medicare--Supplemental Health Insurance Policies	1882(l) New	221(d)(3)	743	1/30-32 2/63	15-17	66-67, 234-240
Medicare--Hospital Providers of Extended Care Services	1883(d) (1)	104(d)(6)	689	1/66-67 2/133	--	8, 146-149
Medicare--Hospital Providers of Extended Care Services	1883(d) (3)	411(b)(4) (D)	770	2/133	--	93, 270-273
Medicare--Hospital Providers of Extended Care Services	1883(f)	104(d)(6)	689	1/67	78	8, 146-149
Medicare--Payment to Hospitals for Inpatient Services	1886(b) (3)(B)(i) (III)	411(b)(1) (A)	768	--	--	91, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Payment to Hospitals for Inpatient Services	1886(b)(3)(B)(i)(IV)	411(b)(1)(A)	768	--	--	91, 270-273
Medicare--Payment to Hospitals for Inpatient Services	1886(b)(3)(B)(i)(IV)	411(b)(1)(B)	768	--	--	91, 270-273
Medicare--Payment to Hospitals for Inpatient Services	1886(b)(3)(B)(i)(V)	411(b)(1)(C)	769	--	--	91, 270-273
Medicare--Payment to Hospitals for Inpatient Services	1886(d)(1)(A)(iii)	411(b)(1)(G)	769	--	--	91, 270-273
Medicare--Payment to Hospitals for Inpatient Services	1886(d)(2)(D)	411(b)(1)(D)	769	--	--	91, 270-273
Medicare--Payment to Hospitals for Inpatient Services	1886(d)(2)(D)	411(b)(1)(H)(i)	769	--	--	91, 270-273
Medicare--Payment to Hospitals for Inpatient Services	1886(d)(3)(A)	411(b)(1)(E)	769	--	--	91, 270-273
Medicare--Payment to Hospitals for Inpatient Services	1886(d)(3)(A)(ii)	411(b)(1)(F)	769	--	--	91, 270-273
Medicare--Payment to Hospitals for Inpatient Services	1886(d)(8)(B)	411(b)(4)(A)(i)	770	--	--	92, 270-273
Medicare--Payment to Hospitals for Inpatient Services	1886(d)(8)(B)	411(b)(4)(A)(ii)	770	--	--	92, 270-273
Medicare--Payment to Hospitals for Inpatient Services	1886(d)(8)(C)	411(b)(4)(B)	770	--	--	92, 270-273
Medicare--Payment to Hospitals for Inpatient Services	1886(d)(9)(C)(iv)	411(b)(3)	769	--	--	92, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Payment to Hospitals for Inpatient Services	1886(e) (6)(B)	411(b)(8) (B)	772	--	--	95, 270-273
Medicare--Payment to Hospitals for Inpatient Services (technical amendment)	1886(f)(1) Redesignated as 1886(f) (1)(A)	411(b)(6) (B)	770	--	--	93, 270-273
Medicare--Payment to Hospitals for Inpatient Services	1886(f) (1)	411(b)(6) (B)	770	--	--	93, 270-273
Medicare--Payment to Hospitals for Inpatient Services	1886(f) (1)(B) New	411(b)(6) (B)	770	--	--	93, 270-273
Medicare--Payment to Hospitals for Inpatient Services	1886(g) (3)(A) (iv)	411(b)(5) (A)	770	--	--	93, 270-273
Medicare--Limitation of Liability of Beneficiaries with Respect to Services Furnished by Excluded Individuals and Entities	1890 Heading	411(i)(4) (D)(ii)(I)	790	--	--	114, 270-273
Medicare--Exclusions from Coverage	1890	411(i)(4) (D)(ii)(II)	790	--	--	114, 270-273
Medicare--Exclusions from Coverage	1890	411(i)(4) (D)(ii)(III)	790	--	--	114, 270-273
Medicare--Exclusions from Coverage	1890	411(i)(4) (D)(ii)(IV)	790	--	--	114, 270-273
Medicare--Exclusions from Coverage	1890	411(i)(4) (D)(ii)(V)	790	--	--	114, 270-273
Medicare--Home Health Quality	1891(a) (3)(A)	411(d)(1) (A)(i)	773	--	--	96, 270-273
Medicare--Home Health Quality	1891(a) (3)(F)	411(d)(1) (A)(ii)	773	--	--	96, 270-273
Medicare--Home Health Quality	1891(a)(4) Stricken	411(d)(1) (A)(iii)	773	--	--	96, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Home Health Quality (technical amendment)	1891(a)(5) Redesignated as 1891(g)(4)	411(d)(1)(A)(iii)	773	--	--	96, 270-273
Medicare--Home Health Quality (technical amendment)	1891(a)(6) Redesignated as 1891(a)(5)	411(d)(1)(A)(iii)	773	--	--	96, 270-273
Medicare--Home Health Quality	1891(c)(1)	411(d)(2)(A)	773	--	--	96, 270-273
Medicare--Home Health Quality	1891(d)(2)(A)	411(d)(2)(B)	774	--	--	96, 270-273
Medicare--Home Health Quality (technical amendment)	1891(f)(2)(A)(i)	411(d)(3)(B)(i)	774	--	--	96, 270-273
Medicare--Home Health Quality	1891(f)(2)(A)(i)	411(d)(3)(B)(ii)	774	--	--	96, 270-273
Medicare--Home Health Quality (technical amendment)	1891(f)(2)(A)(ii)	411(d)(3)(B)(i)	774	--	--	96, 270-273
Medicare--Home Health Quality (technical amendment)	1891(f)(2)(A)(iii)	411(d)(3)(B)(i)	774	--	--	96, 270-273
Medicare--Home Health Quality (technical amendment)	1891(f)(2)(A)	411(d)(3)(B)(i)	774	--	--	96, 270-273
Medicare--Home Health Quality	1891(f)(2)(A)	411(d)(3)(B)(iii)	774	--	--	97, 270-273
Medicare--Offset of Payments	1892 Heading	411(f)(10)(C)(i)(I)	780	--	--	103, 270-273
Medicare--Offset of Payments	1892	411(f)(10)(C)(i)(II)	780	--	--	103, 270-273
Medicare--Offset of Payments	1892(a)(1)(A)	411(f)(10)(C)(i)(IV)	780	--	--	104, 270-273
Medicare--Offset of Payments	1892(a)(2)(C)(ii)	411(f)(10)(A)(i)	780	--	--	103, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicare--Offset of Payments	1892(a)(3)(B)	411(f)(10)(A)(i)	780	--	--	103, 270-273
Medicare--Offset of Payments	1892(a)(4)	411(f)(10)(A)(ii)	780	--	--	103, 270-273
Medicare--Offset of Payments	1892(a)(4)	411(f)(10)(A)(iii)	780	--	--	103, 270-273
Medicare--Offset of Payments	1892(a)(4)	411(f)(10)(C)(i)(III)	780	--	--	104, 270-273
Medicare--Offset of Payments	1892(b)(1)	411(f)(10)(C)(i)(V)	780	--	--	104, 270-273
Medicare--Offset of Payments	1892(b)(1)	411(f)(10)(C)(i)(VI)	781	--	--	104, 270-273
Medicare--Offset of Payments	1892(b)(2)	411(f)(10)(C)(i)(V)	780	--	--	104, 270-273
Medicare--Offset of Payments	1892(b)(2) New	411(f)(10)(C)(i)(VI)	781	--	--	104, 270-273
Medicaid--State Plans for Medical Assistance (conforming amendment)	1902(a)(9)(C)	204(d)(3)	729	--	--	50, 170-172
Medicaid--State Plans for Medical Assistance (technical amendment)	1902(a)(10)(A)(i)(II)	302(a)(1)(A)	751	--	--	72, 253-257
Medicaid--State Plans for Medical Assistance (technical amendment)	1902(a)(10)(A)(i)(III)	302(a)(1)(A)	751	--	--	72, 253-257
Medicaid--State Plans for Medical Assistance	1902(a)(10)(A)(i)(IV) New	302(a)(1)(A)	751	--	--	73, 253-257
Medicaid--State Plans for Medical Assistance	1902(a)(10)(A)(ii)(VI)	411(k)(17)(B)	800	--	--	125, 270-273
Medicaid--State Plans for Medical Assistance	1902(a)(10)(A)(ii)(IX)	302(a)(1)(B)	751	--	--	73, 253-257

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicaid--State Plans for Medical Assistance	1902(a) (10)(A) (ii)(IX)	411(k)(5) (A)	791	--	--	115, 270-273
Medicaid--State Plans for Medical Assistance (conforming amendment)	1902(a) (10)(A) (ii)(X)	301(e)(2) (A)	749	1/26-27 2/57-62	--	71, 253-257
Medicaid--State Plans for Medical Assistance	1902(a) (10)(A) (ii)(X)	411(k)(5) (A)	791	--	--	115, 270-273
Medicaid--State Plans for Medical Assistance	1902(a) (10)(A) (ii)(XI)	411(k)(5) (B)(i)	792	--	--	115, 270-273
Medicaid--State Plans for Medical Assistance (technical amendment)	1902(a) (10)(A) (ii)(XI)	411(k)(5) (B)(ii)	792	--	--	115, 270-273
Medicaid--State Plans for Medical Assistance	1902(a) (10)(C) (i)(III)	303(e)(1)	763	2/31, 65-79, 134	--	85, 257-269
Medicaid--State Plans for Medical Assistance (conforming amendment)	1902(a) (10)(E)	301(e)(2) (B)	749	1/26-27 2/57-62	--	71, 253-257
Medicaid--State Plans for Medical Assistance	1902(a) (10)(E)	301(a)(1)	748	1/26-27 2/17, 57-62, 135	--	70, 253-257
Medicaid--State Plans for Medical Assistance	1902(a) (10)(VII)	302(a)(1) (C)	751	--	--	73, 253-257
Medicaid--State Plans for Medical Assistance (technical amendment)	1902(a) (10)(VIII)	302(b)(1) (A)	751	--	--	73, 253-257
Medicaid--State Plans for Medical Assistance (technical amendment)	1902(a) (10)(IX)	302(b)(1) (B)	751	--	--	73, 253-257
Medicaid--State Plans for Medical Assistance	1902(a) (10)(X) New	302(b)(1) (B)	751	--	--	73-74, 253-257
Medicaid--State Plans for Medical Assistance	1902(a) (13)(C)	411(b)(3) (H)(i)	803	--	--	128, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicaid--State Plans for Medical Assistance	1902(a) (13)(D)	411(b)(3) (H)(ii)	803	--	--	128, 270-273
Medicaid--State Plans for Medical Assistance	1902(a) (13)(D)	411(b)(3) (H)(iii)	803	--	--	128, 270-273
Medicaid--State Plans for Medical Assistance (conforming amendment)	1902(a) (17)	301(e)(2) (C)	749	1/26-27 2/57-62	--	71, 253-257
Medicaid--State Plans for Medical Assistance	1902(a) (28)(D)(i)	411(b)(3) (E)	803	--	--	127, 270-273
Medicaid--State Plans for Medical Assistance	1902(a) (33)(B)	411(b)(6) (C)	804	--	--	129, 270-273
Medicaid--State Plans for Medical Assistance	1902(a) (44)(A)	411(b)(6) (D)	804	--	--	129, 270-273
Medicaid--State Plans for Medical Assistance (technical amendment)	1902(a) (48)	411(n)(3)	807	--	--	131, 270-273
Medicaid--State Plans for Medical Assistance (technical amendment)	1902(a) (49)	303(e)(2)	763	2/65-79	--	85, 257-269
Medicaid--State Plans for Medical Assistance (technical amendment)	1902(a) (49)	411(n)(3)	807	--	--	131, 270-273
Medicaid--State Plans for Medical Assistance (technical amendment)	1902(a) (50)	303(e)(3)	763	2/65-79	--	85, 257-269
Medicaid--State Plans for Medical Assistance	1902(a)(50) New	411(n)(3)	807	--	--	132, 270-273
Medicaid--State Plans for Medical Assistance	1902(a)(51) New	303(e)(4)	763	2/65-79	--	85, 257-269
Medicaid--State Plans for Medical Assistance	1902(c) New	302(c)(1)	752	--	--	74, 253-257
Medicaid--State Plans for Medical Assistance	1902(d)	411(k)(7) (C)	794	--	--	118, 270-273
Medicaid--State Plans for Medical Assistance	1902(e) (2)(A)	411(k)(7) (B)	794	--	--	118, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicaid--State Plans for Medical Assistance	1902(e) (2)(A)	411(k)(7) (D)	794	--	--	118, 270-273
Medicaid--State Plans for Medical Assistance	1902(e) (6)	302(e)(1)	753	--	--	75, 253-257
Medicaid--State Plans for Medical Assistance	1902(e) (7)	302(e)(2) (A)	753	--	--	75, 253-257
Medicaid--State Plans for Medical Assistance (conforming amendment)	1902(e) (7)	302(e)(2) (B)	753	--	--	75, 253-257
Medicaid--State Plans for Medical Assistance (conforming amendment)	1902(e) (7)	302(e)(2) (C)	753	--	--	75, 253-257
Medicaid--State Plans for Medical Assistance	1902(f)	411(k)(10) (G)(iv)	796	--	--	120, 270-273
Medicaid--State Plans for Medical Assistance	1902(i)	411(b)(8) (C)	805	--	--	129, 270-273
Medicaid--State Plans for Medical Assistance	1902(i) (1)	411(b)(8) (C)	805	--	--	129, 270-273
Medicaid--State Plans for Medical Assistance	1902(i) (1)	411(b)(8) (C)	805	--	--	129, 270-273
Medicaid--State Plans for Medical Assistance	1902(i) (2)	411(b)(8) (C)	805	--	--	129, 270-273
Medicaid--State Plans for Medical Assistance	1902(i) (3)	411(b)(8) (C)	805	--	--	129, 270-273
Medicaid--State Plans for Medical Assistance	1902(l) (1)(C)	302(a)(2) (A)(ii)	751	--	--	73, 253-257
Medicaid--State Plans for Medical Assistance	1902(l) (1)(C)	302(a)(2) (A)(i)	751	--	--	73, 253-257
Medicaid--State Plans for Medical Assistance	1902(l)	302(e)(3) (A)	753	--	--	75, 253-257
Medicaid--State Plans for Medical Assistance	1902(l) (2)(A)	302(a)(2) (B)(i)	751	--	--	73, 253-257

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicaid--State Plans for Medical Assistance (technical amendment)	1902(ℓ)(2)(A) Redesignated as 1902(ℓ)(2)(A)(i)	302(a)(2)(B)(ii)	751	--	--	73, 253-257
Medicaid--State Plans for Medical Assistance	1902(ℓ)(2)(A)(ii) New	302(a)(2)(B)(iii)	751	--	--	73, 253-257
Medicaid--State Plans for Medical Assistance	1902(ℓ)(2)(A)(iii) New	302(a)(2)(B)(iii)	751	--	--	73, 253-257
Medicaid--State Plans for Medical Assistance (conforming amendment)	1902(ℓ)(3)	302(e)(3)(B)	753	--	--	75, 253-257
Medicaid--State Plans for Medical Assistance	1902(ℓ)(4) Stricken	302(c)(2)	752	--	--	74, 253-257
Medicaid--State Plans for Medical Assistance	1902(ℓ)(4) New	302(d)	752	--	--	74, 253-257
Medicaid--State Plans for Medical Assistance	1902(m)(3) Stricken	301(e)(2)(D)	749	1/26-27 2/57-62	--	71, 253-257
Medicaid--State Plans for Medical Assistance (technical amendment)	1902(m)(4) Redesignated as 1902(m)(3)	301(e)(2)(D)	749	1/26-27 2/57-62	--	71, 253-257
Medicaid--State Plans for Medical Assistance (technical amendment)	1902(m)(5) Redesignated as 1902(m)(4)	301(e)(2)(D)	749	1/26-27 2/57-62	--	71, 253-257
Medicaid--State Plans for Medical Assistance	1902(q)	411(n)(3)	807	--	--	131-132, 270-273
Medicaid--State Plans for Medical Assistance	1902(r) New	303(d)	762	2/65-79	--	85, 257-269
Medicaid--State Plans for Medical Assistance (technical amendment)	1902(r)(A) Redesignated as 1902(i)	303(e)(5)(A)	763	2/65-79	--	85, 257-269

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicaid--State Plans for Medical Assistance (technical amendment)	1902(r)(B) Redesignated as 1902(ii)	303(e)(5) (A)	763	2/65-79	--	85, 257-269
Medicaid--State Plans for Medical Assistance (technical amendment)	1902(r) Redesignated as 1902(r) (1)	303(e)(5) (B)	763	2/65-79	--	85, 257-269
Medicaid--State Plans for Medical Assistance	1902(r)(2) New	303(e)(5) (C)	763	2/65-79	--	85, 257-269
Medicaid--Payment to States	1903(a) (1)	301(f)	750	1/26-27 2/18, 57-62, 150	--	71, 253-257
Medicaid--Payment to States	1903(c) New	411(k)(13) (A)	798	--	--	122-123, 270-273
Medicaid--Payment to States	1903(f) (2)	411(k)(10) (G)(ii)	796	--	--	120, 270-273
Medicaid--Payment to States (conforming amendment)	1903(f) (4)	302(e)(4)	753	--	--	75, 253-257
Medicaid--Payment to States	1903(i) (2)(A)	411(k)(10) (D)	795	--	--	119-120, 270-273
Medicaid--Payment to States	1903(i) (2)(B)	411(k)(10) (D)	795	--	--	119-120, 270-273
Medicaid--Payment to States	1903(i) (3)	411(k)(6) (B)(x)	794	--	--	118, 270-273
Medicaid--Payment to States	1903(i) (5)	202(h)(2)	718	2/46-51	--	38, 173-199
Medicaid--Payment to States	1903(i) (8)	302(c)(3) (A)	752	--	--	74, 253-257
Medicaid--Payment to States	1903(i)(9) New	302(c)(3) (B)	752	--	--	74, 253-257
Medicaid--Payment to States	1903(m) (2)(F)	411(a)(3) (B)(iii)	768	--	--	91, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicaid--Payment to States	1903(m) (2)(F)	411(k)(7) (A)(i)	794	--	--	118, 270-273
Medicaid--Payment to States	1903(m) (2)(F)	411(k)(7) (A)(ii)	794	--	--	118, 270-273
Medicaid--Payment to States	1903(m) (2)(F)	411(k)(7) (D)	794	--	--	118, 270-273
Medicaid--Payment to States	1903(m) (5)	411(k)(12) (A)	797	--	--	121-122, 270-273
Medicaid--Definitions	1905(a) (5)(B)	411(k)(4)	791	--	--	115, 270-273
Medicaid--Definitions	1905(a) (17)	411(h)(4) (E)	787	--	--	110, 270-273
Medicaid--Definitions--Institution for Mental Diseases	1905(i)	411(k)(14) (A)	798	--	--	123, 270-273
Medicaid--Definitions--Hospice Care	1905(o) (1)(B)	411(k)(8) (B)(i)	794	--	--	118, 270-273
Medicaid--Definitions--Hospice Care	1905(o) (1)(B)	411(k)(8) (B)(ii)	794	--	--	118, 270-273
Medicaid--Definitions--Qualified Medical Beneficiary	1905(p) (1)(B)	301(a)(2)	748	1/26-27 2/17, 57-62, 136	--	70, 253-257
Medicaid--Definitions--Qualified Medical Beneficiary	1905(p) (1)(C)	301(c)(1)	749	1/26-27 2/17, 57-62, 136	--	70, 253-257
Medicaid--Definitions--Qualified Medical Beneficiary	1905(p) (1)(D)	301(c)(2)	749	1/26-27 2/17, 57-62, 136	--	70, 253-257
Medicaid--Definitions (technical amendment)	1905(p) (2)(A) Redesignated as 1905(p) (2)	301(c)(3) (A)	749	1/26-27 2/57-62	--	71, 253-257
Medicaid--Definitions	1905(p) (2)(A)	301(b)(1)	748	1/26-27 2/17, 57-62	--	70, 253-257

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicaid--Definitions (technical amendment)	1905(p)(2)(A) Redesignated as 1905(p)(2)(A)(i)	301(b)(2)	748	1/26-27 2/57-62	--	70, 253-257
Medicaid--Definitions	1905(p)(2)(A)(ii) New	301(b)(3)	748	1/26-27 2/57-62	--	70, 253-257
Medicaid--Definitions	1905(p)(2)(A)(iii) New	301(b)(3)	748	1/26-27 2/57-62	--	70, 253-257
Medicaid--Definitions	1905(p)(2)(B) Stricken	301(c)(3)(B)	749	1/26-27 2/18, 57-62, 136	--	71, 253-257
Medicaid--Definitions--Medical Cost-Sharing	1905(p)(3)(A)	301(d)(1)	749	1/26-27 2/17, 57-62, 136	--	71, 253-257
Medicaid--Definitions--Medical Cost-Sharing	1905(p)(3)(B)	301(d)(2)	749	1/26-27 2/18, 57-62, 136	--	71, 253-257
Medicaid--Definitions--Medical Cost-Sharing	1905(p)(3)(C)	301(d)(2)	749	1/26-27 2/18, 57-62, 136	--	71, 253-257
Medicaid--Definitions	1905(p)(4) New	301(d)(3)	749	1/26-27 2/11, 36	--	71, 253-257
Medicaid--Definitions	1905(p)(5) New	301(g)(2)	750	1/26-27 2/18, 57-62, 137	--	72, 253-257
Medicaid--Inapplicability and Waiver of Certain Requirements (conforming amendment)	1915(a)(1)(B)(ii)(I)	204(d)(3)	729	--	--	50, 170-172
Medicaid--Inapplicability and Waiver of Certain Requirements	1915(c)(7)(B)	411(g)(3)(G)	803	--	--	128, 270-273
Medicaid--Inapplicability and Waiver of Certain Requirements	1915(c)(7)(B)	411(k)(10)(H)	796	--	--	121, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicaid--Inapplicability and Waiver of Certain Requirements	1915(c) (10)	411(k)(10) (A)(i)	794	--	--	118, 270-273
Medicaid--Inapplicability and Waiver of Certain Requirements	1915(c) (10)	411(k)(10) (A)(ii)	794	--	--	118, 270-273
Medicaid--Inapplicability and Waiver of Certain Requirements	1915(d) (5)(B)	411(k)(3) (A)(ii)	791	--	--	115, 270-273
Medicaid--Inapplicability and Waiver of Certain Requirements	1915(d) (5)(B) (iii)(III)	411(k)(3) (A)(i)	791	--	--	115, 270-273
Medicaid--Inapplicability and Waiver of Certain Requirements	1915(d) (5)(C) (i)	411(k)(3) (B)(i)	791	--	--	115, 270-273
Medicaid--Inapplicability and Waiver of Certain Requirements	1915(d) (5)(C) (i)	411(k)(3) (B)(ii)	791	--	--	115, 270-273
Medicaid--Inapplicability and Waiver of Certain Requirements (technical amendment)	1915(e) Redesignated as 1915(f)	411(k)(17) (A)(ii)	799	--	--	124, 270-273
Medicaid--Inapplicability and Waiver of Certain Requirements	1915(e) New	411(k)(17) (A)(iii)	799	--	--	124-125, 270-273
Medicaid--Inapplicability and Waiver of Certain Requirements	1915(e) (2) Stricken	411(k)(17) (A)(ii)	799	--	--	124, 270-273
Medicaid--Inapplicability and Waiver of Certain Requirements (technical amendment)	1915(f) Redesignated as 1915(f) (2)	411(k)(17) (A)(i)	799	--	--	123, 270-273
Medicaid--Inapplicability and Waiver of Certain Requirements	1915(h)	411(k)(17) (A)(iv)	800	--	--	125, 270-273
Medicaid--Use of Enrollment Fees, Premiums, Deductions, Cost-Sharing, and Similar Charges	1916(c) (1)	411(k)(2)	791	--	--	115, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicaid--Liens, Adjustments and Recoveries, and Transfers of Assets	1917(c)	303(b)	760	2/30-31, 65-79, 138-139	--	83-84, 257-269
Medicaid--Liens, Adjustments and Recoveries, and Transfers of Assets	1917(c)(2)(B)(ii)	411(ℓ)(3)(I)	803	--	--	128, 270-273
Medicaid--Requirements for Nursing Facilities	1919(b)(3)(A)(iii)	411(ℓ)(2)(B)	801	--	--	126, 270-273
Medicaid--Requirements for Nursing Facilities	1919(b)(3)(A)(iv)	411(ℓ)(2)(A)	801	--	--	125-126 270-273
Medicaid--Requirements for Nursing Facilities	1919(b)(3)(B)(ii)(III)	411(ℓ)(2)(C)	801	--	--	126, 270-273
Medicaid--Requirements for Nursing Facilities	1919(b)(4)(C)	411(ℓ)(3)(A)(i)	802	--	--	127, 270-273
Medicaid--Requirements for Nursing Facilities	1919(b)(4)(C)	411(ℓ)(3)(A)(ii)	802	--	--	127, 270-273
Medicaid--Requirements for Nursing Facilities	1919(b)(4)(C)	411(ℓ)(3)(A)(iv)	803	--	--	127, 270-273
Medicaid--Requirements for Nursing Facilities	1919(b)(4)(C)(ii)	411(ℓ)(3)(A)(iii)	802	--	--	127, 270-273
Medicaid--Requirements for Nursing Facilities	1919(b)(4)(C)(ii)	411(ℓ)(3)(A)(v)	803	--	--	127, 270-273
Medicaid--Requirements for Nursing Facilities	1919(b)(4)(C)(iii)	411(ℓ)(3)(A)(vi)	803	--	--	127, 270-273
Medicaid--Requirements for Nursing Facilities	1919(b)(5)(A)	411(ℓ)(2)(D)(i)	802	--	--	126, 270-273
Medicaid--Requirements for Nursing Facilities	1919(b)(5)(A)	411(ℓ)(3)(B)	803	--	--	127, 270-273
Medicaid--Requirements for Nursing Facilities	1919(b)(5)(A)(ii)	411(ℓ)(2)(D)(ii)	802	--	--	126, 270-273
Medicaid--Requirements for Nursing Facilities	1919(b)(5)(G)	411(ℓ)(2)(D)(iii)	802	--	--	126, 270-273
Medicaid--Requirements for Nursing Facilities	1919(c)(1)(B)(i)	303(a)(2)	760	--	--	83, 257-269

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicaid--Requirements for Nursing Facilities	1919(c) (2)(A)(v)	411(ℓ)(2) (F)	802	--	--	126, 270-273
Medicaid--Requirements for Nursing Facilities	1919(c) (6)(A)(ii)	411(ℓ)(2) (G)(i)	802	--	--	126, 270-273
Medicaid--Requirements for Nursing Facilities	1919(c) (6)(B)	411(ℓ)(2) (G)(ii)	802	--	--	126, 270-273
Medicaid--Requirements for Nursing Facilities	1919(c)(7) New	411(ℓ)(6) (B)	804	--	--	129, 270-273
Medicaid--Requirements for Nursing Facilities	1919(e) (1)(A)	411(ℓ)(3) (D)(i)	803	--	--	127, 270-273
Medicaid--Requirements for Nursing Facilities	1919(e) (1)(B)	411(ℓ)(3) (D)(ii)	803	--	--	127, 270-273
Medicaid--Requirements for Nursing Facilities	1919(e) (2)(B)	411(ℓ)(2) (H)	802	--	--	126, 270-273
Medicaid--Requirements for Nursing Facilities	1919(e) (3)	411(ℓ)(2) (I)(i)	802	--	--	127, 270-273
Medicaid--Requirements for Nursing Facilities	1919(e) (3)	411(ℓ)(2) (I)(ii)	802	--	--	127, 270-273
Medicaid--Requirements for Nursing Facilities	1919(e) (7)(E)	411(ℓ)(3) (D)(iii)	803	--	--	127, 270-273
Medicaid--Requirements for Nursing Facilities	1919(f) (2)	411(ℓ)(3) (D)(iv)	803	--	--	127, 270-273
Medicaid--Requirements for Nursing Facilities	1919(f)(2) (A)(i)(I)	411(ℓ)(2) (J)	802	--	--	127, 270-273
Medicaid--Requirements for Nursing Facilities	1919(f) (3)	411(ℓ)(2) (I)(i)	802	--	--	127, 270-273
Medicaid--Requirements for Nursing Facilities	1919(f) (3)	411(ℓ)(2) (I)(ii)	802	--	--	127, 270-273
Medicaid--Requirements for Nursing Facilities	1919(f) (7)	411(ℓ)(2) (K)	802	--	--	127, 270-273
Medicaid--Requirements for Nursing Facilities	1919(f) (7)(B)	411(ℓ)(2) (L)(ii)	802	--	--	127, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicaid--Requirements for Nursing Facilities	1919(g) (1)(C)	411(ℓ)(5) (A)	804	--	--	128, 270-273
Medicaid--Requirements for Nursing Facilities	1919(g) (1)(C)	411(ℓ)(5) (B)	804	--	--	128, 270-273
Medicaid--Requirements for Nursing Facilities	1919(g) (1)(C)	411(ℓ)(5) (C)	804	--	--	128, 270-273
Medicaid--Requirements for Nursing Facilities	1919(g) (1)(D)	411(ℓ)(5) (D)	804	--	--	128, 270-273
Medicaid--Requirements for Nursing Facilities	1919(g) (2)(A)(i)	411(ℓ)(5) (E)	804	--	--	128, 270-273
Medicaid--Requirements for Nursing Facilities	1919(g) (3)(C)	411(ℓ)(6) (A)	804	--	--	129, 270-273
Medicaid--Requirements for Nursing Facilities	1919(g) (3)(D)	411(ℓ)(5) (F)	804	--	--	129, 270-273
Medicaid--Requirements for Nursing Facilities	1919(g) (4)	411(ℓ)(5) (G)	804	--	--	129, 270-273
Medicaid--Requirements for Nursing Facilities	1919(h) (1)	411(ℓ)(8) (B)(i)	805	--	--	129, 270-273
Medicaid--Requirements for Nursing Facilities	1919(h) (2)(B)(i)	411(ℓ)(8) (B)(ii)	805	--	--	129, 270-273
Medicaid--Requirements for Nursing Facilities	1919(h) (3)(C)(ii)	411(ℓ)(7) (A)	805	--	--	129, 270-273
Medicaid--Requirements for Nursing Facilities	1919(h) (5)	411(ℓ)(8) (B)(iii)	805	--	--	129, 270-273
Medicaid--Requirements for Nursing Facilities	1919(h) (9)	411(ℓ)(7) (B)	805	--	--	129, 270-273
Medicaid--Presumptive Eligibility for Pregnant Women	1920(b) (2)(D)(i) (I)	411(k)(16) (B)(i)(I)	799	--	--	123, 270-273
Medicaid--Presumptive Eligibility for Pregnant Women (technical amendment)	1920(b) (2)(D)(i) (II)	411(k)(16) (B)(i)(II)	799	--	--	123, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicaid--Presumptive Eligibility for Pregnant Women	1920(b)(2)(D)(i)(III) New	411(k)(16)(B)(i)(III)	799	--	--	123, 270-273
Medicaid--Presumptive Eligibility for Pregnant Women (technical amendment)	1920(b)(2)(D)(ii)	411(k)(16)(B)(ii)	799	--	--	123, 270-273
Medicaid--Presumptive Eligibility for Pregnant Women	1920(b)(2)(D)(iv) New	411(k)(16)(B)(iii)	799	--	--	123, 270-273
Medicaid--Presumptive Eligibility for Pregnant Women	1920(d)(1)(B)	411(k)(16)(A)	799	--	--	123, 270-273
Medicaid--Intermediate Care Facilities for the Mentally Retarded	1922(e)(1)	411(ℓ)(6)(E)	804	--	--	129, 270-273
Medicaid--Intermediate Care Facilities for the Mentally Retarded	1922(e)(2)(A)	411(ℓ)(6)(E)	804	--	--	129, 270-273
Medicaid--References to Laws Directly Affecting Medicaid Program (technical amendment)	1923 Redesignated as 1924	411(k)(6)(B)(i)	793	--	--	117, 270-273
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923 New	411(k)(6)(B)(i)	793	--	--	117-118, 270-273
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923	411(k)(6)(A)(ii)(I)	792	--	--	116, 270-273
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923	411(k)(6)(A)(ii)(II)	792	--	--	116, 270-273
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923	411(k)(6)(A)(iii)(I)	792	--	--	116, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923	411(k)(6) (A)(iii)(II)	792	--	--	116, 270-273
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923	411(k)(6) (A)(iii)(III)	792	--	--	116, 270-273
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923	411(k)(6) (A)(iii)(III)	792	--	--	116, 270-273
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923	411(k)(6) (A)(iv)	792	--	--	116, 270-273
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923	411(k)(6) (A)(v)	792	--	--	116, 270-273
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923	411(k)(6) (A)(vi)(III)	792	--	--	116, 270-273
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923	411(k)(6) (A)(vi)(IV)	792	--	--	116, 270-273
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923	411(k)(6) (A)(vi)(V)	792	--	--	116, 270-273
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923	411(k)(6) (A)(vi)(VI)	792	--	--	116-117, 270-273
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923	411(k)(6) (B)(i)	793	--	--	117, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicaid--Adustment in Payment for Services by Disproportionate Share Hospitals	1923(a)	411(k)(6) (B)(i)	793	--	--	117, 270-273
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923(a)	411(k)(6) (B)(iv)	793	--	--	117, 270-273
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923(a) (1)	411(k)(10) (L)	797	--	--	121, 270-273
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923(a) (1)	411(k)(6) (B)(ii)	793	--	--	117, 270-273
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923(a) (1)	411(k)(6) (B)(iii)	793	--	--	117, 270-273
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923(a) (2)	411(k)(10) (L)	797	--	--	121, 270-273
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923(a) (2)(C) New	302(b)(2)	752	--	--	74, 253-257
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923(a)	411(k)(6) (B)(v)	793	--	--	117, 270-273
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923(b)	411(k)(6) (B)(vi)	793	--	--	117, 270-273
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923(c)	411(k)(6) (B)(vi)	793	--	--	117, 270-273

Subject	S.S. Act Section	P.L. Section	102 Stat.	H. Rep.* 100-105 Pts. 1&2	S. Rep. 100-126	H.C. Rep. 100-661
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923(d) (2)(B)	411(k)(6) (B)(vii)	794	--	--	117, 270-273
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923(e)	411(k)(6) (A)(vii)(I)	793	--	--	117, 270-273
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923	411(k)(6) (A)(vii)(II)	793	--	--	117, 270-273
Medicaid--Adjustment in Payment for Services by Disproportionate Share Hospitals	1923(e) (2)	411(k)(6) (A)(vii)(III)	793	--	--	117, 270-273
Medicaid--References to Laws Directly Affecting Medicaid Program (technical amendment)	1924 Redesignated as 1925	303(a)(1) (A)	754	--	--	76, 257-269
Medicaid--Treatment of Income and Resources for Certain Institutionalized Spouses	1924 New	303(a)(1) (B)	754	2/24-30, 65-79, 139-145	--	76-83, 257-269
Social Services Programs--Limitation on Use of Grants	2005(a) (9)	411(k)(10) (D)	795	--	--	119-120, 270-273

Public Law 100-360
100th Congress

An Act

To amend title XVIII of the Social Security Act to provide protection against catastrophic medical expenses under the medicare program, and for other purposes.

July 1, 1988
[H.R. 2470]

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

Medicare Catastrophic Coverage Act of 1988.
Aged persons.
Insurance.
Health and medical care.
Health care facilities.
42 USC 1305 note.

SECTION 1. SHORT TITLE; REFERENCES IN ACT; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Medicare Catastrophic Coverage Act of 1988".

(b) AMENDMENTS TO THE SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; references in Act; table of contents.

TITLE I--PROVISIONS RELATING TO PART A OF MEDICARE PROGRAM AND SUPPLEMENTAL MEDICARE PREMIUM

Subtitle A—Expansion of Medicare Part A Benefits

Sec. 101. Expanding scope of benefits under part A.
Sec. 102. Deductibles and coinsurance under part A.
Sec. 103. Part A premium for medicare buy-ins.
Sec. 104. Effective dates, transition, and conforming amendments.

Subtitle B—Supplemental Medicare Premium

Sec. 111. Imposition of supplemental medicare premium.
Sec. 112. Establishment of Federal Hospital Insurance Catastrophic Coverage Reserve Fund.
Sec. 113. Study of tax incentives for purchase of coverage for long-term care.

TITLE II—PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM AND TO MEDICARE SUPPLEMENTAL HEALTH INSURANCE

Subtitle A—Expansion of Medicare Part B Benefits

Sec. 201. Limitation on medicare part B cost-sharing.
Sec. 202. Coverage of catastrophic expenses for prescription drugs and insulin.
Sec. 203. Coverage of home intravenous drug therapy services.
Sec. 204. Coverage of screening mammography.
Sec. 205. In-home care for certain chronically dependent individuals.
Sec. 206. Extending home health services.
Sec. 207. Research on long-term care services for medicare beneficiaries.
Sec. 208. Study of adult day care services.

Subtitle B—Medicare Part B Monthly Premium and Financing

Sec. 211. Adjustment in medicare part B premium.
Sec. 212. Establishment of Federal Catastrophic Drug Insurance Trust Fund; fund transfers.
Sec. 213. Creation of Medicare Catastrophic Coverage Account.

Subtitle C—Miscellaneous Provisions

Sec. 221. Voluntary certification of medical supplemental health insurance policies.
Sec. 222. Adjustment of contracts with prepaid health plans.
Sec. 223. Mailing of notice of medicare benefits and information describing participating physician program.
Sec. 224. Changes in civil money penalties for certain practices of health maintenance organizations and competitive medical plans.

TITLE III—PROVISIONS RELATING TO THE MEDICAID PROGRAM

Sec. 301. Requiring medicaid buy-in of premiums and cost-sharing for indigent medicare beneficiaries.
Sec. 302. Coverage and payment for pregnant women and infants with incomes below poverty line.
Sec. 303. Protection of income and resources of couple for maintenance of community spouse.

TITLE IV—UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE, OBRA TECHNICAL CORRECTIONS, AND MISCELLANEOUS PROVISIONS

Subtitle A—United States Bipartisan Commission on Comprehensive Health Care

Sec. 401. Establishment.
Sec. 402. Duties.
Sec. 403. Membership.
Sec. 404. Staff and consultants.
Sec. 405. Powers.
Sec. 406. Report.
Sec. 407. Termination.
Sec. 408. Authorization of appropriations.

Subtitle B—OBRA Technical Corrections

Sec. 411. Technical corrections to certain health care provisions in the Omnibus Budget Reconciliation Act of 1987.

Subtitle C—Miscellaneous Provisions

Sec. 421. Maintenance of effort.
Sec. 422. Rate reduction for medicare eligible Federal annuitants.
Sec. 423. Study and reports by the Office of Personnel Management on offering medicare supplemental plans to Federal medicare eligible individuals, and other changes.
Sec. 424. Benefits counseling and assistance demonstration project for certain medicare and medicaid beneficiaries.
Sec. 425. Case management demonstration projects.
Sec. 426. Extensions of expiring provisions.
Sec. 427. Advisory Committee on Medicare Home Health Claims.
Sec. 428. Prohibition of misuse of symbols, emblems, or names in reference to Social Security or Medicare.
Sec. 429. Demonstration projects with respect to chronic ventilator-dependent units in hospitals.

TITLE I—PROVISIONS RELATING TO PART A OF MEDICARE PROGRAM AND SUPPLEMENTAL MEDICARE PREMIUM

Subtitle A—Expansion of Medicare Part A Benefits

SEC. 101. EXPANDING SCOPE OF BENEFITS UNDER PART A.

Section 1812 (42 U.S.C. 1395d) is amended—

(1) in subsection (a), by striking paragraphs (1) through (4) and inserting the following:

"(1) inpatient hospital services;

"(2) extended care services for up to 150 days during any calendar year;

"(3) home health services; and

"(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each, a subsequent period of 30 days, and a subsequent extension period with respect to which the individual makes an election under subsection (d)(1).";

(2) by amending subsection (b) to read as follows:

"(b) Payment under this part for services furnished to an individual may not be made for—

"(1) extended care services furnished to the individual during a calendar year after such services have been furnished to the individual for 150 days during that year, or

"(2) inpatient psychiatric hospital services furnished to the individual after such services have been furnished to the individual for a total of 190 days during his lifetime.";

(3) by amending subsection (c) to read as follows:

"(c)(1) If an individual is an inpatient of a psychiatric hospital on the first day of medicare entitlement (as defined in paragraph (4)(A)) payment may not be made under this part during the period described in paragraph (2) for inpatient mental health services (as defined in paragraph (4)(B)) in excess of the number of days specified in paragraph (3).

"(2) The period described in this paragraph—

"(A) begins on the first day of medicare entitlement, and

"(B) ends at the end of the first period of 60 consecutive days thereafter on each of which the individual is not receiving inpatient mental health services.

"(3) The number of days specified in this paragraph for an individual is 150 days less the number of days (during the 150-day period immediately before the first day of medicare entitlement) during which the individual was an inpatient of a psychiatric hospital.

"(4) In this subsection:

"(A) The term 'first day of medicare entitlement' means, for an individual, the first day of the first month for which the individual is entitled to benefits under this part.

"(B) The term 'inpatient mental health services' means—

"(i) inpatient psychiatric hospital services, and

"(ii) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness.";

(4) in subsection (d)—

(A) in paragraph (1), by striking "and one subsequent period of 30 days" and inserting ", a subsequent period of 30 days, and a subsequent extension period", and

(B) in paragraph (2)(B), by inserting "or a subsequent extension period" after "30-day period";

(5) in subsection (e), by striking "post-hospital"; and

(6) by striking subsections (f) and (g).

SEC. 102. DEDUCTIBLES AND COINSURANCE UNDER PART A.

Section 1813 (42 U.S.C. 1395e) is amended—

(1) by amending paragraphs (1) through (3) of subsection (a) to read as follows:

"(1)(A) Subject to subparagraph (C), the amount payable for inpatient hospital services furnished to an individual during the individual's first period of hospitalization to begin during a calendar year shall be reduced by a deduction equal to the inpatient hospital deductible for that year or, if less, the charges imposed with respect to such individual for such services, except that, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed.

"(B) For purposes of subparagraph (A), the term 'period of hospitalization' means, with respect to an individual, the period beginning on the first day the individual is furnished inpatient hospital services and ending on the individual's date of discharge (as established by the Secretary for purposes of section 1886) from the hospital (or, in the case of a transfer, hospitals) involved.

"(C) In the case of an individual with respect to whom—

"(i) a period of hospitalization begins during December of any calendar year,

"(ii) an inpatient hospital deductible is imposed with respect to such period of hospitalization, and

"(iii) a period of hospitalization begins during January of the following calendar year,

no inpatient hospital deductible shall be imposed with respect to a period of hospitalization beginning in January of such following year (but such period of hospitalization shall not be taken into account in determining the application of an inpatient hospital deductible for any period of hospitalization beginning for such individual after January 31 of such following year).

Contracts.

"(D) If the Secretary terminates a contract under section 1876 during a year, no inpatient hospital deductible shall be imposed during the remainder of the year in the case of an individual who can demonstrate to the satisfaction of the Secretary that, during a period of enrollment with the organization in the year, the individual was admitted to a hospital for inpatient hospital services for which the organization was obligated to make payment under such section.

"(2)(A) The amount payable to any provider of services under this part for services furnished an individual shall be further reduced by a deduction equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during each calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

"(B) The deductible under subparagraph (A) for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1833(b) to blood or blood cells furnished the individual in the year.

"(3)(A) The amount payable for extended care services furnished an individual in any calendar year shall be reduced by the coinsurance amount (promulgated under subparagraph (C) for that year) for each day (before the 9th day) on which he is furnished such services during the year.

"(B) Before September 1 of each year (beginning with 1988), the Secretary shall estimate the national average per diem reasonable cost recognized under this title for extended care services which will be furnished in the succeeding calendar year.

"(C) The Secretary shall, in September of each year (beginning with 1988) promulgate the coinsurance amount which shall apply to extended care services furnished in the succeeding year. Such amount shall be equal to 20 percent of the national average per diem cost estimated under subparagraph (B) in that year. If the coinsurance amount determined under the preceding sentence is not a multiple of 50 cents, it shall be rounded to the nearest multiple of 50 cents (or, if it is a multiple of 25 cents but not a multiple of 50 cents, to the next higher multiple of 50 cents)."; and

(2) by striking paragraph (3) of subsection (b).

SEC. 103. PART A PREMIUM FOR MEDICARE BUY-INS.

Subsection (d) of section 1818 (42 U.S.C. 1395i) is amended to read as follows: 42 USC 1395i-2.

"(d)(1) The Secretary shall, during September of each year (beginning with 1988), estimate the monthly actuarial rate for months in the succeeding year. Such actuarial rate shall be one-twelfth of the amount which the Secretary estimates (on an average, per capita basis) is equal to 100 percent of the benefits and administrative costs which will be payable from the Federal Hospital Insurance Trust Fund for services performed and related administrative costs incurred in the succeeding year with respect to individuals age 65 and over who will be entitled to benefits under this part during that entire year.

"(2) The Secretary shall, during September of each year determine and promulgate the dollar amount which shall be applicable for premiums for months occurring in the following year. Such amount shall be equal to the monthly actuarial rate determined under paragraph (1) for that following year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

"(3) Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium under this section, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for individuals 65 and older as provided in paragraph (1).". Public information.

SEC. 104. EFFECTIVE DATES, TRANSITION, AND CONFORMING AMENDMENTS.

(a) EFFECTIVE DATE.— 42 USC 1395d note.

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this subtitle shall take effect on January 1, 1989, and shall apply—

(A) to the inpatient hospital deductible for 1989 and succeeding years,

(B) to care and services furnished on or after January 1, 1989,

(C) to premiums for January 1989 and succeeding months, and

(D) to blood or blood cells furnished on or after January 1, 1989.

(2) ELIMINATION OF POST-HOSPITAL REQUIREMENT FOR EXTENDED CARE SERVICES.—The amendments made by this subtitle, insofar as they eliminate the requirement (under section 1812(a)(2) of the Social Security Act) that extended care services are only covered under title XVIII of such Act if they are post-hospital extended care services, shall only apply to extended care services furnished pursuant to an admission to a skilled nursing facility occurring on or after January 1, 1989.

42 USC 1395e note.

(b) HOLD HARMLESS PROVISIONS.—In the case of an individual for whom a spell of illness (as defined in section 1861(a) of the Social Security Act, as in effect on December 31, 1988) began before January 1, 1989, and had not yet ended as of such date—

(1) the amendment made to section 1813(a)(1) of such Act shall not apply to services furnished during that spell of illness during 1989 or 1990, and

(2) the amount of any deductible under section 1813(a)(2) of such Act (as amended by this subtitle) shall be reduced during that spell of illness during 1989 or 1990 to the extent the deductible under such section was applied during the spell of illness.

42 USC 1395ww note.

(c) ADJUSTMENTS IN PAYMENTS FOR INPATIENT HOSPITAL SERVICES.—

(1) PPS HOSPITALS.—In adjusting DRG prospective payment rates under section 1886(d) of the Social Security Act, outlier cutoff points under section 1886(d)(5)(A) of such Act, and weighting factors under section 1886(d)(4) of such Act for discharges occurring on or after October 1, 1988, the Secretary of Health and Human Services shall, to the extent appropriate, take into consideration the reductions in payments to hospitals by medicare beneficiaries resulting from the elimination of a day limitation on medicare inpatient hospital services (under the amendments made by section 101).

(2) PPS-EXEMPT HOSPITALS.—In adjusting target amounts under section 1886(b)(3) of the Social Security Act for cost reporting periods beginning on or after October 1, 1988, the Secretary shall, on a hospital-specific basis, take into consideration the reductions in payments to hospitals by medicare beneficiaries resulting from the elimination of a day limitation on medicare inpatient hospital services (under the amendments made by section 101).

(d) MISCELLANEOUS CONFORMING AMENDMENTS.—

(1) Section 1811 (42 U.S.C. 1395c) is amended by striking "hospital, related post-hospital" and inserting "inpatient hospital services, extended care services".

(2) Section 1814 (42 U.S.C. 1395f) is amended—

(A) in paragraphs (2)(B) and (6) of subsection (a), by striking "post-hospital" each place it appears;

(B) in subsection (a)(2)(B), by striking ", for any of the conditions" and all that follows up to the semicolon;

(C) in subsection (a)(7)(A)—

(i) by striking "and" at the end of clause (i),

(ii) by striking the semicolon at the end of clause (ii) and inserting ", and", and

(iii) by adding at the end the following new clause:

"(iii) in a subsequent extension period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill;"; and

(D) in subsection (d)(3)—

(i) by striking "60 percent" and "80 percent" and inserting "100 percent" both places, and

(ii) by striking "two-thirds of".

(3) Section 1832(b) (42 U.S.C. 1395k(b)) is amended by striking " 'spell of illness'," and the comma before "and".

(4) Section 1861 (42 U.S.C. 1395x) is amended—

(A) by striking subsection (a);

(B) in subsection (e)—

(i) in the matter before paragraph (1), by striking "paragraph (7) of this subsection, and subsection (i) of this section" and inserting "and paragraph (7) of this subsection",

(ii) in the third sentence, by striking "section 1814(f)(2), and subsection (i) of this section" and inserting "and section 1814(f)(2)",

(iii) in the fifth sentence, by striking ", except for purposes of subsection (a)(2),", and

(iv) by striking the second sentence;

(C) by striking subsection (i);

(D) in subsections (v)(1)(G)(i), (v)(2)(A), and (v)(3), by striking "post-hospital" each place it appears; and

(E) in subsection (y)—

(i) by striking "Post-Hospital" in the heading and by striking "post-hospital" each place it appears,

(ii) in paragraph (1), by striking "(except for purposes of subsection (a)(2))",

(iii) in paragraphs (2) and (3), by striking "spell of illness" and "spell" each place either appears and inserting "year",

(iv) in paragraph (2)(A)(i), by striking "30 days" and inserting "45 days",

(v) in paragraph (3), by striking "one-eighth" and all that follows through "31st day" and inserting "the coinsurance amount established under section 1813(a)(3)(C) for each day before the 46th day", and

(vi) by striking paragraph (4).

(5) Section 1866(d) (42 U.S.C. 1395cc(d)) is amended by striking "post-hospital" each place it appears.

(6) Subsections (d)(1) and (f) of section 1883 (42 U.S.C. 1395tt) are amended by striking "post-hospital" each place it appears.

Subtitle B—Supplemental Medicare Premium

SEC. 111. IMPOSITION OF SUPPLEMENTAL MEDICARE PREMIUM.

(a) GENERAL RULE.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to determination of tax liability) is amended by adding at the end thereof the following new part:

Taxes.

"PART VIII—SUPPLEMENTAL MEDICARE PREMIUM

"Sec. 59B. Supplemental medicare premium.

26 USC 59B.

"SEC. 59B. SUPPLEMENTAL MEDICARE PREMIUM.

"(a) IMPOSITION OF PREMIUM.—In the case of an individual to whom this section applies, there is hereby imposed (in addition to any other amount imposed by this subtitle) for each taxable year a supplemental premium equal to the annual premium for such year determined under subsection (c).

"(b) INDIVIDUALS SUBJECT TO PREMIUM.—This section shall apply to an individual for any taxable year if—

"(1) such individual is a medicare-eligible individual for more than 6 full months beginning in the taxable year, and

"(2) such individual's adjusted income tax liability for the taxable year equals or exceeds $150.

"(c) DETERMINATION OF AMOUNT OF SUPPLEMENTAL PREMIUM.—For purposes of this section—

"(1) IN GENERAL.—Except as otherwise provided in this subsection, the annual premium determined under this subsection with respect to any individual for any taxable year shall be equal to the product of—

"(A) the supplemental premium rate determined under subsection (d) or (e) (whichever applies) for the taxable year, multiplied by

"(B) the amount determined by dividing—

"(i) the individual's adjusted income tax liability for the taxable year, by

"(ii) $150.

"(2) LIMITATION ON ANNUAL PREMIUM.—

"(A) YEARS BEFORE 1994.—In the case of any taxable year beginning before 1994, the annual premium determined under this subsection with respect to any individual shall not exceed the limitation determined under the following table:

"In the case of taxable years beginning in:	The limitation is:
1989	$800
1990	850
1991	900
1992	950
1993	1,050.

"(B) YEARS AFTER 1993.—In the case of any taxable year beginning in a calendar year after 1993, the annual premium determined under this subsection with respect to any individual shall not exceed—

"(i) the limitation which would be in effect under this paragraph for taxable years beginning in the preceding calendar year without regard to the last sentence of this subparagraph, increased by

"(ii) the percentage (if any) by which—

"(I) the medicare-part B value for the 2nd preceding calendar year, exceeds

"(II) such value for the 3rd preceding calendar year.

If the limitation determined under the preceding sentence is not a multiple of $50, such limitation shall be rounded to the nearest multiple of $50.

"(C) MEDICARE-PART B VALUE.—

"(i) IN GENERAL.—For purposes of subparagraph (B), the term 'medicare-part B value' means, with respect to any calendar year, an amount equal to the excess of—

"(I) the average per capita part B outlays for the year, over

"(II) 12 times the monthly premium for months in such calendar year established under section 1839 of such Act (without regard to subsections (b), (f), (g)(4), and (g)(5) thereof).

"(ii) AVERAGE PER CAPITA PART B OUTLAYS.—For purposes of clause (i), the term 'average per capita part B outlays' means, with respect to a calendar year—

"(I) the outlays under part B of title XVIII of the Social Security Act for the year, divided by

"(II) the average number of individuals covered under such part during the year.

"(iii) SPECIAL RULE FOR COVERED OUTPATIENT DRUGS.—In applying the limitation under subparagraph (B) with respect to taxable years beginning in any calendar year before 1998, for purposes of this subparagraph—

"(I) the term 'outlays' does not include outlays for covered outpatient drugs (as defined in section 1861(t)(2) of the Social Security Act), and

"(II) the monthly premium shall be computed under clause (i)(II) excluding premiums under section 1839(g) of such Act attributable to the prescription drug monthly premium.

"(3) TABLES.—The annual premium shall be determined under tables which shall be prescribed by the Secretary. Such tables shall be based on the foregoing provisions of this subsection; except that such tables may have adjusted income tax liability brackets of less than $150.

"(d) DETERMINATION OF SUPPLEMENTAL PREMIUM RATE FOR YEARS BEFORE 1994.—In the case of any taxable year beginning before 1994, the supplemental premium rate determined under this subsection shall be the sum of the catastrophic coverage premium rate and the prescription drug premium rate determined under the following table:

"In the case of any taxable year beginning in:	The catastrophic coverage premium rate is:	The prescription drug premium rate is:
1989	$22.50	0
1990	27.14	$10.36
1991	30.17	8.83
1992	30.55	9.95
1993	29.55	12.45.

"(e) SUPPLEMENTAL PREMIUM RATE FOR YEARS AFTER 1993.—

"(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1993, except as provided in paragraph (2), the supplemental premium rate determined under this subsection shall be the sum of—

"(A) the catastrophic coverage premium rate (which would be in effect under this section for taxable years

beginning in the preceding calendar year if paragraph (2) did not apply to any preceding calendar year) adjusted by the percentage determined under paragraph (3) for the calendar year in which the taxable year begins, and

"(B) the prescription drug premium rate (which would be in effect under this section for taxable years beginning in the preceding calendar year if paragraph (2) did not apply to any preceding calendar year) adjusted by the percentage determined under paragraph (4) for the calendar year in which the taxable year begins.

"(2) SUPPLEMENTAL PREMIUM RATE CANNOT GO DOWN, AND CANNOT GO UP BY MORE THAN $1.50.—

"(A) IN GENERAL.—In no event shall the supplemental premium rate determined under this subsection for any taxable year beginning in a calendar year after 1993—

"(i) be less than, or

"(ii) exceed by more than $1.50,

the supplemental premium rate in effect under this section for taxable years beginning in the preceding calendar year.

"(B) DETERMINATION OF COMPONENT RATES WHERE SUBPARAGRAPH (A) APPLIES.—If subparagraph (A) affects the supplemental premium rate determined under this subsection for taxable years beginning in any calendar year, the supplemental premium rate determined after the application of subparagraph (A) shall be allocated between the catastrophic coverage premium rate and the prescription drug premium rate on the basis of the respective amounts of such rates without regard to the application of subparagraph (A).

"(3) PERCENTAGE ADJUSTMENT FOR CATASTROPHIC COVERAGE PREMIUM RATE.—

"(A) IN GENERAL.—The percentage determined under this paragraph for any calendar year shall be the sum of—

"(i) the outlay-premium percentage, and

"(ii) the reserve account percentage.

For purposes of the preceding sentence, negative percentages shall be taken into account as negatives.

"(B) OUTLAY-PREMIUM PERCENTAGE.—

"(i) IN GENERAL.—Except as otherwise provided in this subparagraph, the outlay-premium percentage for any calendar year is—

"(I) the percentage by which the per capita catastrophic outlays in the 2nd preceding calendar year exceed such outlays in the 3rd preceding calendar year, reduced (including below zero) by

"(II) the percentage by which the per capita catastrophic coverage premium liability for the 2nd preceding calendar year exceeds such liability for the 3rd preceding calendar year (determined as if the catastrophic coverage premium rate for the 2nd preceding calendar year were the same as the rate in effect for the 3rd preceding calendar year).

If there is no excess described in subclause (I) or (II), such subclause shall be applied by substituting 'is less than' for 'exceeds' and the percentage determined with such substitution shall be taken into account as a negative percentage.

"(ii) ADJUSTMENT FOR MORE RECENT INCREASES IN COST-OF-LIVING.—If—

"(I) the percentage increase in the CPI for the 12-month period ending with May of the preceding calendar year, exceeds (or is less than)

"(II) such increase for the 12-month period ending with May of the 2nd preceding calendar year,

by at least 1 percentage point, the percentage determined under clause (i) for the calendar year shall be adjusted up (or down, respectively) by ½ of the amount by which such excess (or shortage, respectively) exceeds 1 percent.

"(C) RESERVE ACCOUNT PERCENTAGE.—

"(i) IN GENERAL.—The reserve account percentage for any calendar year is the percentage which the rate change determined under clause (ii) is of the catastrophic coverage premium rate which would be in effect under this section for taxable years beginning in the preceding calendar year if paragraph (2) did not apply to any preceding calendar year. If there is an excess determined under clause (iii), the percentage determined under the preceding sentence shall be taken into account as a negative percentage.

"(ii) DETERMINATION OF RATE CHANGE.—The rate change determined under this clause for any calendar year is the adjustment in the catastrophic coverage premium rate (otherwise in effect for taxable years beginning in the 2nd preceding calendar year) which the Secretary determines would have resulted in an aggregate increase (or decrease) in the premiums imposed by this section for such taxable years equal to 63 percent of the shortfall or excess determined under clause (iii) for the calendar year.

"(iii) DETERMINATION OF SHORTFALL OR EXCESS.—The shortfall (or excess) determined under this clause for any calendar year is the amount by which—

"(I) 20 percent of the outlays during the 2nd preceding calendar year from the Medicare Catastrophic Coverage Account created under section 1841B of the Social Security Act, exceeds (or is less than)

"(II) the balance in such Account as of the close of such 2nd preceding calendar year (determined by taking into account previous premium increases by reason of the reserve account percentage under this subsection or by reason of section 1839(g)(2) of the Social Security Act but not credited to the Account).

"(D) DEFINITIONS.—For purposes of this paragraph—

"(i) PER CAPITA CATASTROPHIC OUTLAYS.—The term 'per capita catastrophic outlays' means, with respect to any calendar year, the amount (as determined by the Secretary of Health and Human Services) equal to—

"(I) the outlays during such year from the Medicare Catastrophic Coverage Account created under section 1841B of the Social Security Act, divided by

"(II) the average number of individuals entitled to receive benefits under part A of title XVIII of the Social Security Act during such calendar year

"(ii) PER CAPITA CATASTROPHIC COVERAGE PREMIUM LIABILITY.—The term 'per capita catastrophic coverage premium liability' means, with respect to any calendar year, the amount (as determined by the Secretary) equal to—

"(I) the aggregate premiums imposed by this section for taxable years beginning in such calendar year to the extent attributable to the catastrophic coverage premium rate, divided by

"(II) the number of individuals who had premium liability under this section for such taxable years.

"(iii) PERCENTAGE INCREASE IN CPI.—The percentage increase in the CPI for any 12-month period shall be the percentage by which the Consumer Price Index (as defined in section 1(f)(5)) for the last month of such period exceeds such Index for the last month of the preceding 12-month period.

"(4) PERCENTAGE ADJUSTMENT FOR PRESCRIPTION DRUG PREMIUM RATE.—The percentage determined under this paragraph for any calendar year shall be determined under rules similar to the rules of paragraph (3); except that—

"(A) in determining the prescription drug premium rate for any calendar year before 1998, the following percentages shall be substituted for 20 percent in paragraph (3)(C)(iii)(I):

"In the case of calendar year:	The percentage is:
1994	75
1995	50
1996	25
1997	25,

"(B) no adjustment by reason of the outlay-premium percentage shall be made for any calendar year before 1998,

"(C) any reference to the Medicare Catastrophic Coverage Account shall be treated as a reference to the Federal Catastrophic Drug Insurance Trust Fund, and

"(D) any reference to the catastrophic coverage premium rate shall be treated as a reference to the prescription drug premium rate.

"(f) DEFINITIONS AND SPECIAL RULES.—

"(1) MEDICARE-ELIGIBLE INDIVIDUAL.—For purposes of this section—

"(A) IN GENERAL.—Except as otherwise provided in this paragraph, the term 'medicare-eligible individual' means, with respect to any month, any individual who is entitled to (or, on application without the payment of an additional premium, would be entitled to) benefits under part A of title XVIII of the Social Security Act for such month.

"(B) EXCEPTIONS.—The term 'medicare-eligible individual' shall not include for any month—

"(i) any individual who is entitled to benefits under part A of title XVIII of the Social Security Act for such month solely by reason of the payment of a premium under section 1818 of such Act, or

"(ii) any qualified nonresident.

"(2) SPECIAL RULES FOR JOINT RETURNS.—In the case of a joint return—

"(A) WHERE PREMIUM APPLIES TO BOTH SPOUSES.—If both spouses meet the requirements of subsection (b)(1) for the taxable year—

"(i) such spouses shall be treated as 1 individual for purposes of applying this section, except that

"(ii) the limitation of subsection (c)(2) shall be twice the amount which would otherwise apply.

"(B) WHERE PREMIUM APPLIES TO ONLY 1 SPOUSE.—If only 1 spouse meets the requirements of subsection (b)(1) for the taxable year—

"(i) this section shall be applied separately with respect to such spouse, and

"(ii) the adjusted income tax liability of such spouse shall be determined under paragraph (4)—

"(I) by taking into account one-half of the income tax liability determined with respect to the joint return, and

"(II) by taking into account under clause (ii) of paragraph (4)(C) only amounts attributable to such spouse.

"(3) SEPARATE RETURNS BY MARRIED INDIVIDUALS.—If an individual is married as of the close of the taxable year (within the meaning of section 7703) but does not file a joint return for the taxable year and such individual does not live apart from his spouse at all times during the taxable year—

"(A) the limitation of subsection (c)(2) shall be twice the amount which would otherwise apply if both the individual and the spouse of the individual meet the requirements of subsection (b)(1) with respect to the calendar year in which the taxable year begins (determined without regard to subparagraph (B) of this paragraph),

"(B) if such individual does not otherwise meet the requirements of subsection (b)(1), such individual shall be treated as meeting the requirements of subsection (b)(1) for the taxable year if the spouse of such individual meets such requirements with respect to the calendar year in which the taxable year begins, and

"(C) in applying subparagraph (C) of paragraph (4)—

"(i) the dollar limitation of clause (i) thereof shall be ½ of the amount which applies to a joint return where both spouses meet the requirements of subsection (b)(1), and

"(ii) the individual shall be deemed to receive social security benefits during the taxable year in an amount not less than ½ of the aggregate social security benefits received by such individual and his spouse during the taxable year.

"(4) ADJUSTED INCOME TAX LIABILITY.—For purposes of this section—

"(A) IN GENERAL.—The term 'adjusted income tax liability' means an amount equal to the income tax liability, reduced by the excess (if any) of—

"(i) 15 percent of the governmental retiree exclusion amount (if any) determined under subparagraph (C) for the taxable year, over

"(ii) the amount of the credit allowable under section 22 for the taxable year.

"(B) INCOME TAX LIABILITY.—The term 'income tax liability' means—

"(i) the tax imposed by this chapter (determined without regard to this section), reduced by

"(ii) the credits allowed under part IV of this subchapter (other than under sections 31, 33, and 34).

"(C) GOVERNMENTAL RETIREE EXCLUSION AMOUNT.—The governmental retiree exclusion amount for any taxable year is the lesser of—

"(i) $6,000 ($9,000 in the case of a joint return where both spouses meet the requirements of subsection (b)(1) for the taxable year), or

"(ii) the amount which is received as an annuity (whether for a period certain or during 1 or more lives) under a governmental plan (as defined in the 1st sentence of section 414(d)) and which is includible in gross income under section 72 for the taxable year.

The amount determined under the preceding sentence shall be reduced by the social security benefits (as defined in section 86(d)) received during the taxable year.

"(D) INDEXING.—In the case of any taxable year beginning in a calendar year after 1989, subparagraph (C)(i) shall be applied by substituting for each dollar amount contained in such subparagraph an amount equal to—

"(i) the dollar amount which would be in effect under subparagraph (C)(i) for taxable years beginning in the preceding calendar year without regard to the last sentence of this subparagraph, increased by

"(ii) the cost-of-living adjustment determined under section 215(i) of the Social Security Act for the calendar year in which the taxable year begins.

Any amount determined under the preceding sentence shall be rounded to the nearest multiple of $50.

"(5) QUALIFIED NONRESIDENT.—

"(A) IN GENERAL.—For purposes of paragraph (1), the term 'qualified nonresident' means, with respect to any month during the taxable year, any individual if—

"(i) such individual is not furnished during such taxable year or any of the 4 preceding taxable years any service for which a claim for payment is made under part A of title XVIII of the Social Security Act,

"(ii) such individual is not entitled to benefits under part B of title XVIII of the Social Security Act at any time during such taxable year or any of the 4 preceding taxable years, and

"(iii) such individual is present in a foreign country or countries for at least 330 full days during—

"(I) the 12-month period ending at the close of the taxable year, and

"(II) each of the 4 consecutive preceding 12-month periods.

"(B) SPECIAL RULE FOR INDIVIDUALS WHO DIE DURING THE TAXABLE YEAR.—An individual who dies during the taxable year shall be treated as meeting the requirement of subparagraph (A)(iii)(I) if such individual is present in a foreign country or countries for at least a number of full days equal to 90 percent of the days during such taxable year before the date of death.

"(6) COORDINATION WITH OTHER PROVISIONS.—

"(A) NOT TREATED AS MEDICAL EXPENSE.—For purposes of section 213, the supplemental premium imposed by this section for any taxable year shall not be treated as an expense paid for medical care.

"(B) NOT TREATED AS TAX FOR CERTAIN PURPOSES.—The supplemental premium imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

"(i) the amount of any credit allowable under this chapter, or

"(ii) the amount of the minimum tax imposed by section 55.

"(C) TREATED AS TAX FOR SUBTITLE F.—For purposes of subtitle F, the supplemental premium imposed by this section shall be treated as if it were a tax imposed by section 1.

"(D) SECTION 15 NOT TO APPLY.—Section 15 shall not apply to the supplemental premium imposed by this section.

"(7) SECTION NOT TO AFFECT LIABILITY TO POSSESSIONS, ETC.—This section shall not apply for purposes of determining liability to any possession of the United States. For purposes of sections 932 and 7654, the supplemental premium imposed by this section shall not be treated as a tax imposed by this chapter.

"(8) SHORT TAXABLE YEARS.—In the case of a taxable year of less than 12 months, this section shall be applied under regulations prescribed by the Secretary."

(b) INFORMATION REPORTING.—

(1) Subsection (a) of section 6050F of such Code is amended by striking "and" at the end of paragraph (1), by redesignating paragraph (2) as paragraph (3), and by inserting after paragraph (1) the following new paragraph: 26 USC 6050F.

"(2) whether any individual meets the requirements of section 59B(b)(1) with respect to the calendar year (determined without regard to section 59B(f)(1)(B)(ii)), and".

(2) Section 6050F(b) of such Code is amended—

(A) by inserting "or making the determination under subsection (a)(2)" after "payments" in paragraph (1), and

(B) by inserting "and the information required under subsection (a)(2)," after "reductions," in paragraph (2).

(3) Section 6050F(c)(1)(A) of such Code is amended by inserting "and the information required under subsection (a)(2)" after "section 86(d)(1)(A)".

(c) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 of such Code is amended by adding at the end thereof the following new item:

"Part VIII. Supplemental medicare premium."

(d) ANNOUNCEMENT OF SUPPLEMENTAL PREMIUM RATE.—In the case of calendar year 1993 or any calendar year thereafter— 26 USC 59B note.

(1) not later than July 1 of such calendar year, the Secretary of the Treasury or his delegate shall make an announcement of the estimated supplemental premium rate under section 59B of the Internal Revenue Code of 1986 for taxable years beginning in the following calendar year, and

(2) not later than October 1 of such calendar year, the Secretary of the Treasury or his delegate shall make an announcement of the actual supplemental premium rate under such section for such taxable years.

26 USC 59B note.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to taxable years beginning after December 31, 1988.

(2) WAIVER OF ESTIMATED TAX REQUIREMENT FOR YEARS BEGINNING IN 1989.—In the case of a taxable year beginning in 1989, the premium imposed by section 59B of the Internal Revenue Code of 1986 (as added by this section) shall not be treated as a tax for purposes of applying section 6654 of such Code.

SEC. 112. ESTABLISHMENT OF FEDERAL HOSPITAL INSURANCE CATASTROPHIC COVERAGE RESERVE FUND.

(a) IN GENERAL.—Part A of title XVIII is amended by inserting after section 1817 the following new section:

"FEDERAL HOSPITAL INSURANCE CATASTROPHIC COVERAGE RESERVE FUND

42 USC 1395i-1a.

"SEC. 1817A. (a)(1) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Hospital Insurance Catastrophic Coverage Reserve Fund' (in this section referred to as the 'Reserve Fund'). The Reserve Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1) and amounts appropriated under paragraph (2).

"(2) There are hereby appropriated to the Reserve Fund, from the supplemental premiums imposed by section 59B of the Internal Revenue Code of 1986 attributable to the supplemental catastrophic premium rate, amounts equivalent to 100 percent of the amount of outlays made under this part attributable to the amendments made by the Medicare Catastrophic Coverage Act of 1988. The amounts appropriated by the preceding sentence shall be transferred from time to time (not less frequently than monthly) from the general fund in the Treasury to the Reserve Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the premiums, specified in the preceding sentence, paid to or deposited into the Treasury and on the basis of outlays, specified in the previous sentence, made; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the appropriate amounts specified in such sentence. At the close of each year, the transfers under this subsection shall reflect all premiums (described in this paragraph) paid or deposited into the Treasury in the year.

"(3) With respect to monies transferred to the Reserve Fund, no transfers, authorizations of appropriations, or appropriations are permitted.

"(b) The provisions of subsections (b) through (e) of section 1817 shall apply to the Reserve Fund in the same manner as they apply to the Federal Hospital Insurance Trust Fund, except that the Board of Trustees and Managing Trustee of the Reserve Fund shall be composed of the members of the Board of Trustees and the Manag-

ing Trustee, respectively, of the Federal Hospital Insurance Trust Fund.

"(c) In this part, with respect to the Reserve Fund, the terms 'outlays' and 'receipts' mean, with respect to a quarter or other period, gross outlays and receipts, as such terms are employed in the 'Monthly Treasury Statement of Receipts and Outlays of the United States Government (MTS)', as published by the Department of the Treasury, for months in such quarter or other period.".

(b) INTEREST ADJUSTMENT.—In July 1990, the Secretary of the Treasury shall calculate the interest lost to the Federal Hospital Insurance Catastrophic Coverage Reserve Fund due to the lag between the outlays (attributable to the amendments made by this Act) from the Federal Hospital Insurance Trust Fund during 1989 and the transfers made to such Reserve Fund to cover such outlays. Appropriations under section 1817A(a)(2) of the Social Security Act (as inserted by subsection (a)) shall include the amount calculated under the previous sentence. 42 USC 1395i-1a note.

SEC. 113. STUDY OF TAX INCENTIVES FOR PURCHASE OF COVERAGE FOR LONG-TERM CARE.

(a) IN GENERAL.—The Secretary of the Treasury (in this section referred to as the "Secretary") shall conduct a study of Federal tax policies to promote the private financing of long-term care (as defined in subsection (d)). The study shall identify alternative methods of creating incentives, through the tax system, to encourage individuals to purchase insurance coverage for long-term care. The study shall also consider the cost to the United States Treasury and the potential benefits to consumers, including whether the incentives would benefit all or most of the population requiring protection.

(b) CONSULTATION.—The Secretary shall conduct the study required by subsection (a) in consultation with representatives of the insurance industry, providers of long-term care, and consumers.

(c) REPORT.—The Secretary shall report the results of the study required by subsection (a) to the Congress not later than November 30, 1988, together with the Secretary's recommendations for any changes in Federal law that the Secretary determines to be appropriate to promote the private financing of long-term care.

(d) LONG-TERM CARE DEFINED.—For purposes of this section, the term "long-term care" includes care and services provided by nursing homes, home health agencies, and other mechanisms for the delivery of long-term care services.

TITLE II—PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM AND TO MEDICARE SUPPLEMENTAL HEALTH INSURANCE

Subtitle A—Expansion of Medicare Part B Benefits

SEC. 201. LIMITATION ON MEDICARE PART B COST-SHARING.

(a) IN GENERAL.—Section 1833 (42 U.S.C. 1395l) is amended—

(1) in subsection (c)—

(A) by striking "subsections (a) and (b)" and inserting "subsection (a) through (c)",

(B) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B),

(C) by striking "this subsection" and inserting "this paragraph", and

(D) by striking "(c)" and inserting "(d)(1)";

(2) by redesignating subsection (d) as paragraph (2);

(3) in subsection (g), by striking "(a) and (b)" and inserting "(a) through (c)"; and

(4) by inserting after subsection (b) the following new subsection:

"(c)(1) Notwithstanding subsections (a) and (b), if an individual has incurred out-of-pocket part B cost sharing (as defined in paragraph (2)) in a calendar year (beginning with 1990) in an amount equal to the part B catastrophic limit (established under paragraph (3)) for the year, payment under this part with respect to any additional incurred expenses in the calendar year shall be made as if—

"(A) the deduction described in the second sentence of subsection (b) (relating to blood) no longer applied, and

"(B) '100 percent' and '0 percent' were substituted for '80 percent' and '20 percent', respectively, each place either appears in subsections (a) and (i)(2), in sections 1834(a)(1)(A), 1834(e)(1)(C), 1835(b)(2), and 1866(a)(2)(A), and in subsections (b)(2) and (b)(3) of section 1881, except as such provisions may apply to in-home care.

"(2) In this subsection, the term 'out-of-pocket part B cost sharing' means, with respect to an individual covered under this part, the amounts of expenses that the individual incurs that are attributable to—

"(A) the deductions established under subsection (b), and

"(B) the difference between the payment amount provided under this part and the payment amount that would be provided if '100 percent' and '0 percent' were substituted for '80 percent' and '20 percent', respectively, each place either appears in subsections (a) and (i)(2), in sections 1834(a)(1)(A), 1834(e)(1)(C), 1835(b)(2), and 1866(a)(2)(A), and in subsections (b)(2) and (b)(3) of section 1881.

"(3)(A) The part B catastrophic limit for 1990 is $1,370. The part B catastrophic limit for any succeeding year shall be such an amount (rounded to the nearest multiple of $1) as the Secretary estimates will result, in that succeeding year, in 7 percent of the average number of individuals enrolled under this part (other than individuals enrolled with an eligible organization under section 1876 or an organization described in subsection (a)(1)(A)) during the year becoming entitled to benefits under this subsection.

"(B) Not later than September 1 of each year (beginning with 1990), the Secretary shall promulgate the part B catastrophic limit under this paragraph for the succeeding year.

Contracts.

"(4) In the case of an organization receiving payment under clause (A) of subsection (a)(1) or under a reasonable cost reimbursement contract under section 1876, in applying paragraph (1), the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect the aggregate increase in payments that would otherwise be made with respect to enrollees in

such an organization if payments were made other than under such clause or such a contract on an individual-by-individual basis.

"(5)(A) Except as provided in subparagraph (B), expenses incurred by a medicare beneficiary for out-of-pocket part B cost-sharing shall be counted (consistent with subparagraph (C)) whether or not, at the time the expenses were incurred, the beneficiary was enrolled in a plan under section 1833(a)(1)(A) or under section 1876. In this paragraph, with respect to a medicare beneficiary enrolled in such a plan, the term 'out-of-pocket part B cost-sharing' includes deductibles and coinsurance under the plan for items and services covered under this part.

"(B) In the case of a medicare beneficiary enrolled in a month in a buy-out plan (as defined in subparagraph (D))—

"(i) expenses incurred by the beneficiary for items and services reimbursed under the plan shall not be treated as out-of-pocket part B cost-sharing for purposes of paragraph (1), but

"(ii) the beneficiary is deemed to have incurred, for each month of such enrollment, expenses for out-of-pocket part B cost-sharing in an amount equal to the actuarial value (with respect to a month in the year involved) of the deductible and coinsurance amounts under part B (as computed by the Secretary for purposes of section 1876(e)(1), other than with respect to covered outpatient drugs) applicable on the average to individuals in the United States.

"(C) The Secretary may not enter into a contract with an organization under section 1876, or provide for payment under section 1833(a)(1)(A) with respect to an organization, with respect to a plan that is not a buy-out plan, unless the organization provides assurances, satisfactory to the Secretary, that— Contracts.

"(i) the organization will maintain and make available, for its enrollees and in coordination with the appropriate carriers under this part, an accounting of expenses incurred in each year under the plan for out-of-pocket part B cost-sharing (as defined in subparagraph (A)); and

"(ii) the organization will not undertake to charge a beneficiary during a year for services for which payment may be made under this part (other than for covered outpatient drugs) after the individual has incurred (whether through the organization or otherwise) out-of-pocket part B cost sharing in the year in an amount equal to the part B catastrophic limit established under paragraph (1) for the year.

"(D) In this paragraph, the term 'buy-out plan' means a plan under section 1833(a)(1)(A) or offered by an organization under section 1876 and with respect to which—

"(i) the actuarial value of the coinsurance and deductibles under the plan with respect to benefits (other than covered outpatient drugs) under this title (as determined by the Secretary),

is less than 50 percent of—

"(ii) the actuarial value of the coinsurance and deductibles for such benefits for all medicare beneficiaries (as determined by the Secretary) applicable on the average to individuals in the United States.

"(E) In this subsection, the term 'medicare beneficiary' means, with respect to a month, an individual covered for benefits under this part for the month.".

(b) LIMITATION ON CHARGES WHEN CATASTROPHIC LIMIT REACHED.—Section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended by adding at the end the following new sentence: "A provider of services may not impose a charge under the first sentence of this subparagraph for services for which payment is made to the provider pursuant to section 1833(c) (relating to catastrophic benefits).".

(c) NOTICE FOR BENEFICIARIES REACHING CATASTROPHIC LIMIT.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

(1) by striking "and" at the end of subparagraph (G),

(2) by inserting "and" at the end of subparagraph (H), and

(3) by inserting after subparagraph (H) the following new subparagraph:

"(I) will provide each individual, who is determined to have incurred (or has had paid on the individual's behalf) sufficient out-of-pocket part B cost sharing in a calendar year to qualify for payment for additional incurred expenses to be made pursuant to section 1833(c), with a notice that states that the individual has reached the part B catastrophic limit on out-of-pocket cost sharing for the year;".

(d) CONFORMING AMENDMENT.—The second sentence of section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended by striking "1833(c)" and inserting "1833(d)(1)".

SEC. 202. COVERAGE OF CATASTROPHIC EXPENSES FOR PRESCRIPTION DRUGS AND INSULIN.

(a) DESCRIPTION OF COVERED OUTPATIENT DRUGS.—Section 1861 (42 U.S.C. 1395x) is amended—

(1) by amending subparagraph (J) of subsection (s)(2) to read as follows:

"(J) covered outpatient drugs (as defined in subsection (t)); and", and

(2) in subsection (t)—

(A) by inserting "and paragraph (2)" after "subsection (m)(5)",

(B) by inserting "(1)" after "(t)", and

(C) by adding at the end the following new paragraphs:

"(2) Subject to paragraph (3), the term 'covered outpatient drug' means—

"(A) a drug which may be dispensed only upon prescription and—

"(i) which is approved for safety and effectiveness as a prescription drug under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act or which is approved under section 505(j) of such Act;

"(ii)(I) which was commercially used or sold in the United States before the date of the enactment of the Drug Amendments of 1962 or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) which has not been the subject of a final determination by the Secretary that it is a 'new drug' (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act to enforce section 502(f) or 505(a) of such Act; or

"(iii)(I) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling;

"(B) a biological product which—

"(i) may only be dispensed upon prescription,

"(ii) is licensed under section 351 of the Public Health Service Act, and

"(iii) is produced at an establishment licensed under such section to produce such product; and

"(C) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act.

"(3)(A) The term 'covered outpatient drug' does not include any drug, biological product, or insulin provided as, as part of, or as incident to, any of the following (and for which payment may be included under this title):

"(i) Inpatient hospital services (described in subsection (b)(2)).

"(ii) Extended care services (described in subsection (h)(5)).

"(iii) Physicians' services under subparagraph (A) or (B) of subsection (s)(2).

"(iv) Dialysis supplies under subsection (s)(2)(F).

"(v) Antigens under subsection (s)(2)(G).

"(vi) Blood clotting factors for hemophiliacs under subsection (s)(2)(I).

"(vii) Services of a physician assistant under subsection (s)(2)(K)(ii).

"(viii) Pneumococcal, hepatitis B, or influenza vaccines under subsection (s)(10).

"(ix) Rural health clinic services (under subsection (aa)(1)).

"(x) Comprehensive outpatient rehabilitation facility services (under subsection (cc)(1)).

"(xi) Hospice care (as defined in subsection (dd)(1)).

"(xii) Certified nurse-midwife service (as defined in subsection (gg)(1)).

"(xiii) A covered surgical procedure in an ambulatory surgical center (under section 1832(a)(2)(F)(i)).

"(B) With respect to covered outpatient drugs dispensed in 1990, the term 'covered outpatient drug' is limited—

"(i) to drugs described in paragraph (2)(A) used in immunosuppressive therapy, and

"(ii) to covered home IV drugs (as defined in paragraph (4)).

"(C) The term 'covered outpatient drug' does not include a drug that is intravenously administered in a home setting unless it is a covered home IV drug.

"(4)(A) The term 'covered home IV drug' means a covered outpatient drug dispensed to an individual that—

"(i) is intravenously administered in a place of residence used as the individual's home, and

"(ii)(I) is an antibiotic drug and the Secretary has not determined, for the specific drug or for the indication to which it is applied, that the drug cannot generally be administered safely and effectively in a home setting, or

"(II) is not an antibiotic drug and the Secretary has determined, for the specific drug and the indication for which the drug is being applied, that the drug can generally be administered safely and effectively in a home setting.

"(B) Not later than January 1, 1990 (and periodically thereafter), the Secretary shall publish a list of the drugs, and indications for such drugs, that are covered home IV drugs (as defined in subparagraph (A)), with respect to which home intravenous drug therapy may be provided under this title.".

(b) DEDUCTIBLE AND PAYMENT AMOUNTS.—Part B is amended—

(1) in subsection (a)(1) of section 1833 (42 U.S.C. 1395l(b)), as amended by section 411(h)(7)(A)(v)(I) of this Act—

(A) by striking "and" before "(L)", and

(B) by adding at the end the following: "and (M) with respect to expenses incurred for covered outpatient drugs, the amounts paid shall be the amounts determined under section 1834(c)(2)";

(2) in subsection (a)(2) of such section by inserting "(other than covered outpatient drugs)" after "(2) in the case of services";

(3) in subsection (b) of such section—

(A) in clause (1), by inserting "or for covered outpatient drugs" after "1861(s)(10)(A)", and

(B) in clause (2), by inserting "or with respect to covered outpatient drugs" after "home health services"; and

(4) by adding at the end of section 1834 (42 U.S.C. 1395m) the following new subsection:

"(c) PAYMENT FOR COVERED OUTPATIENT DRUGS.—

"(1) DEDUCTIBLE.—

"(A) APPLICATION.—

"(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), payment shall be made under paragraph (2) only with respect to expenses incurred by an individual for covered outpatient drugs during a calendar year on or after such date in the year as the Secretary determines that the individual has incurred expenses in the year for covered outpatient drugs (during a period in which the individual is entitled to benefits under this part) equal to the amount of the catastrophic drug deductible specified in subparagraph (C) for that year.

"(ii) DEDUCTIBLE NOT APPLIED FOR POST-HOSPITAL HOME INTRAVENOUS DRUG THERAPY.—The catastrophic drug deductible established under this paragraph shall not apply to covered home IV drugs dispensed in conjunction with home intravenous drug therapy services which are part of a continuous course of such therapy initiated while the individual was an inpatient in a hospital.

"(iii) DEDUCTIBLE NOT APPLIED TO 1ST YEAR IMMUNOSUPPRESSIVES.—The catastrophic drug deductible established under this paragraph shall not apply to

drugs described in section 1861(t)(2)(A) used in immunosuppressive therapy and furnished, to an individual who receives an organ transplant for which payment is made under this title, within 1 year after the date of the transplant.

"(B) RESPONSE TO APPLICATION.—If the system described in section 1842(o)(4) has not been established and an individual applies to the Secretary to establish that the individual has met the requirement of subparagraph (A), the Secretary shall promptly notify the individual (and, if the application was submitted by or through a participating pharmacy, the pharmacy) as to the date (if any) as of which the individual has met such requirement.

"(C) CATASTROPHIC DRUG DEDUCTIBLE AMOUNT.—

"(i) IN GENERAL.—Subject to subparagraph (D), the catastrophic drug deductible specified in this subparagraph for—

"(I) 1990 is $550,

"(II) 1991 is $600,

"(III) 1992 is $652, and

"(IV) any succeeding year, is such an amount as the Secretary determines will result in 16.8 percent of the average number of individuals covered under this part (other than individuals enrolled with an eligible organization under section 1876 or an organization described in section 1833(a)(1)(A)) during that succeeding year having incurred expenses for covered outpatient drugs sufficient to meet the catastrophic drug deductible so determined.

"(ii) ROUNDING.—Any amount determined under this subparagraph which is not a multiple of $1 shall be rounded to the nearest multiple of $1.

"(iii) PUBLICATION.—Before May 1 of each year (beginning with 1992) the Secretary shall publish in the Federal Register a proposed regulation establishing the amount of the catastrophic drug deductible under this subparagraph for the following year. During the last 3 days of September of such year, the Secretary shall publish in the Federal Register the final regulation establishing the amount of such deductible for the following year, which amount may not be greater than the amount specified in the proposed regulation.

Federal Register, publication. Regulations.

"(2) PAYMENT AMOUNT.—

"(A) IN GENERAL.—Subject to the catastrophic drug deductible established under paragraph (1)(A) and except as provided in subparagraph (C), the amounts payable under this part with respect to a covered outpatient drug is equal to the payment percent (specified in subparagraph (B)) of the lesser of—

"(i) the actual charge for the drug, or

"(ii) the applicable payment limit established under paragraph (3).

"(B) PAYMENT PERCENT.—For purposes of subparagraph (A), the payment percent is 100 percent minus the applicable coinsurance percent (specified in subparagraph (C)).

"(C) COINSURANCE PERCENT.—For purposes of subparagraph (B), the coinsurance percent—

"(i) for covered home IV drugs and for drugs described in paragraph (1)(A)(iii) (relating to immunosuppressive therapy during the 1st year after transplant), is 20 percent; and

"(ii) for other covered outpatient drugs dispensed—

"(I) in 1990 or 1991, is 50 percent,

"(II) in 1992 is 40 percent, and

"(III) in 1993 or a succeeding year is 20 percent.

Contracts.

"(D) TREATMENT OF CERTAIN COST-BASED PREPAID ORGANIZATIONS.—In applying subparagraph (A) in the case of an organization under a reasonable cost reimbursement contract under section 1876 and in the case of an organization receiving payment under section 1833(a)(1)(A) and providing coverage of covered outpatient drugs, the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect the aggregate increase in payments that would otherwise be made with respect to enrollees in such an organization if payments were made other than under such clause or such a contract on an individual-by-individual basis.

"(3) PAYMENT LIMITS.—

"(A) PAYMENT LIMIT FOR NON-MULTIPLE SOURCE DRUGS AND MULTIPLE-SOURCE DRUGS WITH RESTRICTIVE PRESCRIPTIONS.—In the case of a drug that either is not a multiple source drug (as defined in paragraph (9)(A)) or is a multiple source drug and has a restrictive prescription (as defined in paragraph (9)(B)), the payment limit for the drug under this paragraph for a payment calculation period is equal to the lesser of—

"(i) the 90th percentile of the actual charges (computed on a statewide basis, carrier-wide basis, or other appropriate geographic area basis, as specified by the Secretary) for the drug for the second previous payment calculation period, adjusted (as the Secretary determines to be appropriate) to reflect the number of tablets (or other dosage units) dispensed; or

"(ii) the amount of the administrative allowance (established under paragraph (4)) plus the product of—

"(I) the number of tablets (or other dosage units) dispensed, and

"(II) the per tablet or unit average wholesale price for such drug (as determined under subparagraph (C) for the period for purposes of this subparagraph);

except that clause (i) shall not apply to covered outpatient drugs dispensed before January 1, 1992.

"(B) PAYMENT LIMIT FOR MULTIPLE SOURCE DRUGS WITHOUT RESTRICTIVE PRESCRIPTIONS.—In the case of a drug that is a multiple source drug but does not have a restrictive prescription, the payment limit for the drug under this paragraph for a payment calculation period is equal to the amount of the administrative allowance (established under paragraph (4)) plus the product of—

"(i) the number of tablets (or other dosage units) dispensed, and

"(ii) the unweighted median of the per tablet or unit average wholesale prices (determined under subparagraph (C) for purposes of this subparagraph) for such drug for the period.

"(C) DETERMINATION OF UNIT PRICE.—

"(i) IN GENERAL.—For purposes of this paragraph, the Secretary shall determine, with respect to the dispensing of a covered outpatient drug in a payment calculation period (beginning on or after January 1, 1990), the per tablet or unit average wholesale price for the drug.

"(ii) BASIS FOR DETERMINATIONS.—

"(I) DETERMINATION FOR NON-MULTIPLE-SOURCE DRUGS.—For purposes of subparagraph (A), such determination shall be based on a biannual survey conducted by the Secretary of a representative sample of direct sellers, wholesalers, or pharmacies (as appropriate) of wholesale (or comparable direct) prices (excluding discounts to pharmacies); except that if, because of low volume of sales for the drug or other appropriate reasons or in the case of covered outpatient drugs during 1990, the Secretary determines that such a survey is not appropriate with respect to a specific drug, such determination shall be based on published average wholesale (or comparable direct) prices for the drug.

"(II) DETERMINATION FOR MULTIPLE-SOURCE DRUGS.—For purposes of subparagraph (B), the Secretary may base the determination under this subparagraph on the published average wholesale (or comparable direct) prices for the drug or on a biannual survey conducted by the Secretary of a representative sample of direct sellers, wholesalers, or pharmacists (as appropriate) of wholesale (or comparable direct) prices (excluding discounts to pharmacies).

"(III) COMPLIANCE WITH SURVEY REQUIRED.—If a wholesaler or direct seller of a covered outpatient drug refuses, after being requested by the Secretary, to provide the information required in a survey under this clause, or deliberately provides information that is false, the Secretary may impose a civil money penalty of not to exceed $10,000 for each such refusal or provision of false information. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). Information gathered pursuant to the survey shall not be disclosed except as the Secretary determines to be necessary to carry out the purposes of this part.

Law enforcement and crime.

Classified information.

"(iii) QUANTITY AND TIMING.—Such determination shall be based on the price or prices for purchases in reasonable quantities and shall be made for a payment calculation period based on prices for the first day of

the first month of the previous payment calculation period.

"(iv) GEOGRAPHIC BASIS.—The Secretary shall make such determination, and calculate the payment limits under this paragraph, on a national basis; except that the Secretary may make such determination, and calculate such payment limits, on a regional basis to take account of limitations on the availability of drug products and variations among regions in the average wholesale prices for a drug product.

"(4) ADMINISTRATIVE ALLOWANCE FOR PURPOSES OF PAYMENT LIMITS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), for drugs dispensed in—

"(i) 1990 or 1991, the administrative allowance under this paragraph is—

"(I) $4.50 for drugs dispensed by a participating pharmacy, or

"(II) $2.50 for drugs dispensed by another pharmacy; or

"(ii) a subsequent year, the administrative allowance under this paragraph is the administrative allowance under this paragraph for the preceding year increased by the percentage increase (if any) in the implicit price deflator for gross national product (as published by the Department of Commerce in its 'Survey of Current Business') over the 12-month period ending with August of such preceding year.

Any allowance determined under the clause (ii) which is not a multiple of 1 cent shall be rounded to the nearest multiple of 1 cent.

"(B) ADJUSTMENT IN ALLOWANCE FOR MAIL SERVICE PHARMACIES.—The Secretary may, by regulation and after consultation with pharmacists, elderly groups, and private insurers, reduce the administrative allowances established under subparagraph (A) for any drug dispensed by a mail service pharmacy (as defined by the Secretary) based on differences between such pharmacies and other pharmacies with respect to operating costs and other economies.

"(5) ASSURING APPROPRIATE PRESCRIBING AND DISPENSING PRACTICES.—

Health care professionals.

"(A) IN GENERAL.—The Secretary shall establish a program to identify (and to educate physicians and pharmacists concerning)—

"(i) instances or patterns of unnecessary or inappropriate prescribing or dispensing practices for covered outpatient drugs,

"(ii) instances or patterns of substandard care with respect to such drugs, and

"(iii) potential adverse reactions.

"(B) STANDARDS.—In carrying out the program under subparagraph (A), the Secretary shall establish for each covered outpatient drug standards for the prescribing of the drug which are based on accepted medical practice. In establishing such standards, the Secretary shall incorporate standards from such current authoritative compendia as the Secretary may select; except that the Secretary may

Safety.

modify such a standard by regulation on the basis of scientific and medical information that such standard is not consistent with the safe and effective use of the drug.

"(C) PROHIBITION OF FORMULARY.—Nothing in this title (including paragraph (8)), other than sections 1861(t)(4)(A) and 1862(c), shall be construed as authorizing the Secretary to exclude from coverage or to deny payment—

"(i) for any specific covered outpatient drug, or specific class of covered outpatient drug, or

"(ii) for any specific use of such a drug for a specific indication unless such exclusion is pursuant to section 1862(a)(1) based on a finding by the Secretary that such use is not safe or is not effective. Safety.

"(6) TREATMENT OF CERTAIN PREPAID ORGANIZATIONS.—

"(A) GENERAL RULE COUNTING PREPAID PLAN EXPENSES TOWARDS THE CATASTROPHIC DRUG DEDUCTIBLE.—Except as provided in subparagraph (B), expenses incurred by (or on behalf of) a medicare beneficiary for covered outpatient drugs shall be counted (consistent with subparagraph (C)) toward the catastrophic drug deductible established under paragraph (1) whether or not, at the time the expenses were incurred, the beneficiary was enrolled in a plan under section 1833(a)(1)(A) or under section 1876.

"(B) TREATMENT OF DRUG BUY-OUT PLAN EXPENSES.—In the case of a medicare beneficiary enrolled in a month in a drug buy-out plan (as defined in subparagraph (D))—

"(i) expenses incurred by the beneficiary for covered outpatient drugs reimbursed under the plan shall not be counted towards the catastrophic drug deductible, but

"(ii) if the individual disenrolls from the plan during the year, the beneficiary is deemed to have incurred, for each month of such enrollment, expenses for covered outpatient drugs in an amount equal to the actuarial value (with respect to such month) of the deductible for covered outpatient drugs (as computed by the Secretary for purposes of section 1876(e)(1)) applicable on the average to individuals in the United States.

"(C) TREATMENT OF EXPENSES FOR COVERED OUTPATIENT DRUGS INCURRED WHILE ENROLLED IN A PREPAID PLAN OTHER THAN A DRUG BUY-OUT PLAN.—The Secretary may not enter into a contract with an organization under section 1876, or provide for payment under section 1833(a)(1)(A) with respect to an organization which provides reimbursement for covered outpatient drugs, with respect to a plan that is not a drug buy-out plan, unless the organization provides assurances, satisfactory to the Secretary, that—

"(i) the organization will maintain and make available, for its enrollees and in coordination with the appropriate carriers under this part, an accounting of expenses incurred by (or on behalf of) enrollees under the plan for covered outpatient drugs; and

"(ii) the organization will take into account, in any deductibles established under the plan in a year with respect to covered outpatient drugs under this part, the amounts of expenses for covered outpatient drugs in-

curred in the year by (or on behalf of) the beneficiary and otherwise counted towards the catastrophic drug deductible in the year.

"(D) DRUG BUY-OUT PLAN DEFINED.—In this paragraph, the term 'drug buy-out plan' means a plan under section 1833(a)(1)(A) or offered by an organization under section 1876 and with respect to which—

"(i) the amount of any deductible under the plan with respect to covered outpatient drugs under this title, is less than 50 percent of—

"(ii) the catastrophic drug deductible specified in paragraph (1)(C).

"(E) MEDICARE BENEFICIARY DEFINED.—In this subsection, the term 'medicare beneficiary' means, with respect to a month, an individual covered for benefits under this part for the month.

"(F) TREATMENT OF PLAN CHARGES.—In the case of covered outpatient drugs furnished by an eligible organization under section 1876(b) or an organization described in section 1833(a)(1)(A) which does not impose charges on covered outpatient drugs dispensed to its members, for purposes of this subsection the actual charges of the organization shall be the organization's standard charges to members, and other individuals, not entitled to benefits with respect to such drugs.

"(7) PHYSICIAN GUIDE.—

"(A) IN GENERAL.—The Secretary shall develop, and update annually, an information guide for physicians concerning the comparative average wholesale prices of at least 500 of the most commonly prescribed covered outpatient drugs. Such guide shall, to the extent practicable, group covered outpatient drugs (including multiple source drugs) in a manner useful to physicians by therapeutic category or with respect to the conditions for which they are prescribed. Such guide shall specify the average wholesale prices on the basis of the amount of the drug required for a typical daily therapeutic regimen.

"(B) MAILING GUIDE.—The Secretary shall provide for mailing, in January of each year (beginning with 1991), a copy of the guide developed and updated under subparagraph (A)—

"(i) to each hospital with an agreement in effect under section 1866,

"(ii) to each physician (as defined in section 1861(r)(1)) who routinely provides services under this part, and

"(iii) to Social Security offices, senior citizen centers, and other appropriate places.

"(8) REPORTS ON OUTLAYS AND RECEIPTS; SPECIAL COST CONTROLS.—

"(A) COMPILATION OF INFORMATION.—The Secretary shall compile information on—

"(i) manufacturers' prices for covered outpatient drugs, and on charges of pharmacists for covered outpatient drugs, and

"(ii) the use of covered outpatient drugs by individuals entitled to benefits under this part.

The information compiled under clause (i) shall include a comparison of the increases in prices and charges for covered outpatient drugs during each 6 month period (beginning with January 1987) with the semiannual average increase in such prices and charges during the 6 years beginning with 1981.

"(B) REPORTS.—The Secretary shall submit to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report, in May and November of 1989 and 1990 and in May of each succeeding year, providing the information compiled under subparagraph (A). For each such report submitted after 1991, the report shall include an explanation of the extent to which the increases in outlays for covered outpatient drugs under this part are due to the factors described in subparagraphs (A)(i) and (A)(ii).

"(C) MONTHLY REPORTS ON OUTLAYS AND RECEIPTS.—Within 30 days after the end of each month (beginning with October 1991 and ending with April 1993), the Secretary shall report to Congress on the outlays and receipts of the Federal Catastrophic Drug Insurance Trust Fund (in this paragraph referred to as the 'Trust Fund') in the month.

"(D) BUDGETARY INFORMATION.—

"(i) IN GENERAL.—In each report submitted under subparagraph (B) after 1991, the Secretary shall include information on—

"(I) the projected budgetary status of the Trust Fund for the succeeding year,

"(II) the projected increases in manufacturers' prices for covered outpatient drugs and in charges of pharmacists for covered outpatient drugs,

"(III) the projected level of utilization of covered outpatient drugs by medicare beneficiaries, and

"(IV) the projected administrative costs relating to covered outpatient drugs.

"(ii) DETERMINATION AND PUBLICATION OF ANY OUTLAY CONTROLS FOR 1993 AND 1994.—For each such report in 1992 and 1993, the Secretary—

"(I) shall determine in the report whether the anticipated outlays and receipts of the Trust Fund for the succeeding year will provide for at least the minimum contingency margin specified in subparagraph (F) for that succeeding year, and

"(II) if not, shall include in the report (and shall publish in the Federal Register by May 1 of the year a proposed regulation to carry out) changes in the provisions of this part (consistent with subparagraph (E)) in order to reduce outlays from the Trust Fund in that succeeding year sufficiently to provide for the minimum contingency margin specified in subparagraph (F).

Federal Register, publication. Regulations.

Any changes described in subclause (II) in such report shall reflect appropriately each of the anticipated causes of increased or unanticipated outlays for covered outpatient drugs.

Federal Register, publication.

"(iii) EFFECTIVENESS OF REGULATORY CHANGES.—If proposed regulations are published under clause (ii)(II) in 1992 or 1993, during the last 3 days of September of such year, the Secretary shall publish in the Federal Register a final regulation to implement the changes described in such clause. Notwithstanding any other provision of this part, but subject to subparagraph (E) and unless otherwise provided by law, such changes shall become effective on January 1 of the succeeding year and shall apply only during that succeeding year. Such final regulation may not revise the proposed regulation in a manner that would result in a greater reduction in outlays than would have been the case under the proposed regulation.

"(E) LIMITATION ON CHANGES.—In making regulatory changes under subparagraph (D), the Secretary may not—

"(i) provide for a formulary (in violation of paragraph (5)(C));

"(ii) change the methodology for determining whether for a year an individual has met the catastrophic drug deductible established under paragraph (1)(A); or

"(iii) increase the coinsurance percent under paragraph (2)(C) for a year above the coinsurance percent in effect during the previous year.

Clause (ii) shall not be construed as prohibiting the Secretary from increasing the amount of the catastrophic drug deductible under paragraph (1)(A).

"(F) MINIMUM CONTINGENCY MARGIN DEFINED.—In this paragraph, the term 'minimum contingency margin' means—

"(i) for 1993, 50 percent, and

"(ii) for 1994, 25 percent.

Such margin shall be determined as of the close of each calendar year and shall be determined based on the total outlays from the Trust Fund during the year.

"(9) DEFINITIONS.—In this subsection:

"(A) MULTIPLE SOURCE DRUG.—

"(i) IN GENERAL.—The term 'multiple source drug' means, with respect to a payment calculation period, a covered outpatient drug for which there are 2 or more drug products which—

"(I) are rated as therapeutically equivalent (under the Food and Drug Administration's most recent publication of 'Approved Drug Products with Therapeutic Equivalence Evaluations'),

"(II) except as provided in clause (ii), are pharmaceutically equivalent and bioequivalent, as defined in clause (iii) and as determined by the Food and Drug Administration, and

"(III) are sold or marketed during the period.

"(ii) EXCEPTION.—Subclause (II) of clause (i) shall not apply if the Food and Drug Administration changes by regulation (after an opportunity for public comment of 90 days) the requirement that, for purposes of the publication described in clause (i)(I), in order for drug products to be rated as therapeutically equivalent,

they must be pharmaceutically equivalent and bioequivalent, as defined in clause (iii).

"(iii) DEFINITIONS.—For purposes of this subparagraph:

"(I) PHARMACEUTICALLY EQUIVALENT.—Drug products are pharmaceutically equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form and meet compendial or other applicable standards of strength, quality, purity, and identity.

"(II) BIOEQUIVALENT.—Drugs are bioequivalent if they do not present a known or potential bioequivalence problem or, if they do present such a problem, are shown to meet an appropriate standard of bioequivalence.

"(III) SOLD OR MARKETED.—A drug is considered to be sold or marketed during a period if it is listed in the publications referred to in clause (i)(I), unless the Secretary determines that such sale or marketing is not actually taking place.

"(B) RESTRICTIVE PRESCRIPTION.—A drug has a 'restrictive prescription' only if—

"(i) in the case of a written prescription, the prescription for the drug indicates, in the handwriting of the physician or other person prescribing the drug and with an appropriate phrase (such as 'brand medically necessary') recognized by the Secretary, that the particular drug must be dispensed, or

"(ii) in the case of a prescription issued by telephone—

"(I) the physician or other person prescribing the drug (through use of such an appropriate phrase) states that the particular drug must be dispensed, and

"(II) the physician or other person submits to the pharmacy involved, within 30 days after the date of the telephone prescription, a written confirmation which is in the handwriting of the physician or other person prescribing the drug and which indicates with such appropriate phrase that the particular drug was required to have been dispensed.

"(C) PAYMENT CALCULATION PERIOD.—The term 'payment calculation period' means the 6-month period beginning with January of each year and the 6-month period beginning with July of each year.

"(D) OUTLAYS; RECEIPTS.—The terms 'outlays' and 'receipts' mean, with respect to a year or other period, gross outlays and receipts, as such terms are employed in the 'Monthly Treasury Statement of Receipts and Outlays of the United States Government (MTS)', as published by the Department of the Treasury, for months in such year or other period.".

(c) PARTICIPATING PHARMACIES; CIVIL MONEY PENALTIES.—

(1) PARTICIPATING PHARMACIES.—Section 1842 (42 U.S.C. 1395t) is amended— 42 USC 1395u.

(A) in subsection (h)(1), by inserting before the period at the end of the second sentence the following: ", except that, with respect to a supplier of covered outpatient drugs, the term 'participating supplier' means a participating pharmacy (as defined in subsection (o)(1))";

(B) in subsection (h)(4), is amended by adding at the end the following: "In publishing directories under this paragraph, the Secretary shall provide for separate directories (wherever appropriate) for participating pharmacies."; and

(C) by adding at the end the following new subsection:

"(o)(1) For purposes of this section, the term 'participating pharmacy' means, with respect to covered outpatient drugs dispensed on or after January 1, 1991, an entity which is authorized under a State law to dispense covered outpatient drugs and which has entered into an agreement with the Secretary, providing at least the following:

"(A) The entity agrees to accept payment under this part on an assignment-related basis for all covered outpatient drugs dispensed to an individual entitled to benefits under this part (in this subsection referred to as a 'medicare beneficiary') during a year after—

"(i) the Secretary has notified the entity, through the electronic system described in subparagraph (D)(i), or

"(ii) in the absence of such a system, the entity is otherwise notified that the Secretary has determined,

that the individual has met the catastrophic drug deductible with respect to such drugs under section 1834(c)(1) for the year.

"(B) The entity agrees—

"(i) not to refuse to dispense covered outpatient drugs stocked by the entity to any medicare beneficiary, and

"(ii) not to charge medicare beneficiaries (regardless of whether or not the beneficiaries are enrolled under a prepaid health plan or with eligible organization under section 1876) more for such drugs than the amount it charges to the general public (as determined by the Secretary in regulations).

"(C) The entity agrees to keep patient records (including records on expenses) for all covered outpatient drugs dispensed to all medicare beneficiaries.

"(D) The entity agrees to submit information (in a manner specified by the Secretary to be necessary to administer this title) on all purchases of covered outpatient drugs dispensed to medicare beneficiaries.

"(E) The entity agrees—

"(i) to offer to counsel, or to offer to provide information (consistent with State law respecting the provision of such information) to, each medicare beneficiary on the appropriate use of a drug to be dispensed and whether there are potential interactions between the drug and other drugs dispensed to the beneficiary; and

"(ii) to advise the beneficiary on the availability (consistent with State laws respecting substitution of drugs) of therapeutically equivalent covered outpatient drugs.

"(F) The entity agrees to provide the information requested by the Secretary in surveys under section 1834(c)(3)(C)(ii).

Nothing in this paragraph shall be construed as requiring a pharmacy operated by an eligible organization (described in section 1876(b)) or an organization described in section 1833(a)(1)(A) for the

exclusive benefit of its members to dispense covered outpatient drugs to individuals who are not members of the organization.

"(2) The Secretary shall provide to each participating pharmacy—

"(A) a distinctive emblem (suitable for display to the public) indicating that the pharmacy is a participating pharmacy, and

"(B) upon request, such electronic equipment and technical assistance (other than the costs of obtaining, maintaining, or expanding telephone service) as the Secretary determines may be necessary for the pharmacy to submit claims using the electronic system established under paragraph (4). Claims.

"(3) The Secretary shall provide for periodic audits of participating pharmacies to assure—

"(A) compliance with the requirements for participation under this title, and

"(B) the accuracy of information submitted by the pharmacies under this title.

"(4) The Secretary shall establish, by not later than January 1, 1991, a point-of-sale electronic system for use by carriers and participating pharmacies in the submission of information respecting covered outpatient drugs dispensed to medicare beneficiaries under this part. Science and technology. Communications and telecommunications.

"(5) Notwithstanding subsection (b)(3)(B), payment for covered outpatient drugs may be made on the basis of an assignment described in clause (ii) of that subsection only to a participating pharmacy.".

(2) CIVIL MONEY PENALTIES FOR VIOLATION OF PARTICIPATION AGREEMENT, FOR EXCESSIVE CHARGES FOR NONPARTICIPATING PHARMACIES AND FOR FAILURE TO PROVIDE SURVEY INFORMATION.—Section 1128A(a) (42 U.S.C. 1320a-7a(a)) is amended—

(A) by striking "or" at the end of paragraph (1),

(B) in paragraph (2)(C), by inserting "or to be a participating pharmacy under section 1842(o)" after "1842(h)(1)",

(C) by striking ", or" at the end of paragraph (2) and inserting a semicolon,

(D) by adding "or" at the end of paragraph (3), and

(E) by inserting after paragraph (3) the following new paragraph:

"(4) in the case of a participating or nonparticipating pharmacy (as defined for purposes of part B of title XVIII)—

"(A) presents or causes to be presented to any person a request for payment for covered outpatient drugs dispensed to an individual entitled to benefits under part B of title XVIII and for which the amount charged by the pharmacy is greater than the amount the pharmacy charges the general public (as determined by the Secretary in regulations), or

"(B) fails to provide the information requested by the Secretary in a survey under section 1834(c)(3)(C)(ii);".

(d) LIMITATION ON LENGTH OF PRESCRIPTION.—Section 1862(c) (42 U.S.C. 1395y(c)) is amended—

(1) by redesignating subparagraphs (A) through (D) of paragraph (1) as clauses (i) through (iv), respectively;

(2) in paragraph (2)(A), by striking "paragraph (1)" and inserting "subparagraph (A)";

(3) by redesignating subparagraphs (A) and (B) of paragraph (2) as clauses (i) and (ii), respectively;

(4) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively;

(5) by inserting "(1)" after "(c)"; and

(6) by adding at the end the following new paragraph:

"(2) No payment may be made under part B for any expense incurred for a covered outpatient drug if the drug is dispensed in a quantity exceeding a supply of 30 days or such longer period of time (not to exceed 90 days, except in exceptional circumstances) as the Secretary may authorize.".

(e) USE OF CARRIERS, FISCAL INTERMEDIARIES, AND OTHER ENTITIES IN ADMINISTRATION.—

(1) AUTHORIZING USE OF OTHER ENTITIES IN ELECTRONIC CLAIMS SYSTEM.—Section 1842(f) (42 U.S.C. 1395u(f)) is amended—

(A) by striking "and" at the end of paragraph (1),

(B) by striking the period at the end of paragraph (2) and inserting "; and", and

(C) by adding at the end the following new paragraph:

"(3) with respect to implementation and operation (and related functions) of the electronic system established under subsection (o)(4), a voluntary association, corporation, partnership, or other nongovernmental organization, which the Secretary determines to be qualified to conduct such activities.".

(2) ADDITIONAL FUNCTIONS OF CARRIERS.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)), as amended by section 201(c) of this Act, is amended—

(A) by striking "and" at the end of subparagraph (H), and

(B) by inserting after subparagraph (I) the following new subparagraphs:

"(J) if it makes determinations or payments with respect to covered outpatient drugs, will—

"(i) receive information transmitted under the electronic system established under subsection (o)(4), and

"(ii) respond to requests by participating pharmacies (and individuals entitled to benefits under this part) as to whether or not such an individual has met the catastrophic drug deductible established under section 1834(c)(1)(A) for a year; and

Contracts.

"(K) will enter into such contracts with organizations described in subsection (f)(3) as the Secretary determines may be necessary to implement and operate (and for related functions with respect to) the electronic system established under subsection (o)(4) for covered outpatient drugs under this part;".

(3) SPECIAL CONTRACT PROVISIONS FOR ELECTRONIC CLAIMS SYSTEM.—

(A) PAYMENT ON OTHER THAN A COST BASIS.—Section 1842(c)(1)(A) (42 U.S.C. 1395u(c)(1)(A)) is amended—

(i) by inserting "(i)" after "(c)(1)(A)",

(ii) in the first sentence, by inserting ", except as provided in clause (ii)," after "under this part, and", and

(iii) by adding at the end the following new clause:

"(ii) To the extent that a contract under this section provides for implementation and operation (and related functions) of the electronic system established under subsection (o)(4) for covered outpatient drugs, the Secretary may provide for payment for such activities based on any method of payment determined by the Secretary to be appropriate.".

(B) APPLICATION OF DIFFERENT PERFORMANCE STANDARDS.—The Secretary of Health and Human Services, before entering into contracts under section 1842 of the Social Security Act with respect to the implementation and operation (and related functions) of the electronic system for covered outpatient drugs, shall establish standards with respect to performance with respect to such activities. The provisions of section 1153(e)(2), and paragraphs (1) and (2) of section 1153(h), of such Act shall apply to such activities in the same manner as they apply to contracts with peer review organizations, instead of the requirements of the last 2 sentences of section 1842(b)(2) of such Act. Contracts. 42 USC 1395u note.

(C) USE OF REGIONAL CARRIERS.—Section 1842(b)(2) is amended by adding at the end the following new sentence: "With respect to activities relating to implementation and operation (and related functions) of the electronic system established under subsection (o)(4), the Secretary may enter into contracts with carriers under this section to perform such activities on a regional basis.". Contracts.

(4) ADJUSTMENT OF CARRIER OBLIGATIONS.—

(A) NO TOLL-FREE TELEPHONE NUMBER REQUIRED OF LIMITED CARRIERS.—Section 1842(h)(2) (42 U.S.C. 1395u(h)(2)) is amended by inserting "(other than a carrier described in subsection (f)(3))" after "Each carrier".

(B) DELAY IN APPLICATION OF COORDINATED BENEFITS WITH MEDIGAP.—The provisions of subparagraph (B) of section 1842(h)(3) of the Social Security Act shall not apply to covered outpatient drugs (other than drugs described in section 1861(s)(2)(J) of such Act as of the date of the enactment of this Act) dispensed before January 1, 1993. 42 USC 1395u note.

(5) BATCH PROMPT PROCESSING OF CLAIMS.—Section 1842(c) (42 U.S.C. 1395u(c)) is amended—

(A) in paragraphs (2)(A) and (3)(A), by striking "Each" and inserting "Except as provided in paragraph (3), each";

(B) by adding at the end the following new paragraph:

"(4)(A) Each contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), with respect to claims for payment for covered outpatient drugs shall provide for a payment cycle under which each carrier will, on a monthly basis, make a payment with respect to all claims which were received and approved for payment in the period since the most recent date on which such a payment was made with respect to the participating pharmacy or individual submitting the claim. Contracts. Claims.

"(B) If payment is not issued, mailed, or otherwise transmitted within 5 days of when such a payment is required to be made under subparagraph (A), interest shall be paid at the rate used for purposes of section 3902(a) of title 31, United States Code (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after such 5-day period and ending on the date on which payment is made.".

(f) MODIFICATION OF HMO/CMP CONTRACTS.—

(1) SEPARATE ACTUARIAL DETERMINATION FOR COVERED OUTPATIENT DRUG BENEFIT.—Section 1876(e)(1) (42 U.S.C. 1395mm(e)(1)) is amended by adding at the end thereof the following new sentence: "The preceding sentence shall be applied separately with respect to covered outpatient drugs.".

(2) ADDITIONAL OPTIONAL BENEFITS.—Section 1876(g)(3)(A) (42 U.S.C. 1395mm(g)(3)(A)) is amended by striking "rate" and inserting "rates".

(g) REQUIRING SUBMISSION OF DIAGNOSTIC INFORMATION.—Section 1842 (42 U.S.C. 1395u), as amended by subsection (c)(1)(C), is amended by adding at the end the following new subsection:

Health care professionals.

"(p)(1) Each request for payment, or bill submitted, for an item or service furnished by a physician for which payment may be made under this part shall include the appropriate diagnosis code (or codes) as established by the Secretary for such item or service.

"(2) In the case of a request for payment for an item or service furnished by a physician on an assignment-related basis which does not include the code (or codes) required under paragraph (1), payment may be denied under this part.

Law enforcement and crime.

"(3) In the case of a request for payment for an item or service furnished by a physician not submitted on an assignment-related basis and which does not include the code (or codes) required under paragraph (1)—

"(A) if the physician knowingly and willfully fails to provide the code (or codes) promptly upon request of the Secretary or a carrier, the physician may be subject to a civil money penalty in an amount not to exceed $2,000, and

"(B) if the physician knowingly, willfully, and in repeated cases fails, after being notified by the Secretary of the obligations and requirements of this subsection, to include the code (or codes) required under paragraph (1), the physician may be subject to the sanction described in section 1842(j)(2)(A).

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under subparagraph (A) in the same manner as they apply to a penalty or proceeding under section 1128A(a).".

(h) CONFORMING AMENDMENTS.—

(1) The first sentence of section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended—

(A) by inserting "1834(c)," after "1833(b),", and

Drugs and drug abuse.

(B) by inserting "and in the case of covered outpatient drugs, applicable coinsurance percent (specified in section 1834(c)(2)(C)) of the lesser of the actual charges for the drugs or the payment limit (established under section 1834(c)(3))" after "established by the Secretary".

(2) Section 1903(i)(5) (42 U.S.C. 1396b(i)(5)) is amended by striking "section 1862(c)" and inserting "section 1862(c)(1)".

42 USC 1395m note.

(i) REPORTS ON MEDICARE BENEFICIARY DRUG EXPENSES.—

(1) HHS.—The Secretary of Health and Human Services, by not later than April 1, 1989—

(A) using data from the 1987 National Medical Expenditures Survey (conducted by the National Center for Health Services Research and Health Care Technology Assessment), shall report to Congress on expenses incurred by medicare beneficiaries for outpatient prescription drugs, and

(B) shall provide the Director of the Congressional Budget Office with such data from that Survey as the Director may request to make the estimates required under paragraph (2).

(2) REESTIMATION OF COSTS.—The Director of the Congressional Budget Office shall transmit to the Congress, not later

than June 1, 1989, or, if later, 60 days after the date of providing data requested under paragraph (1)(B), the Director's estimate of the outlays which will be made (in each of fiscal years 1990, 1991, 1992, and 1993) under the medicare program for covered outpatient drugs (under the amendments made by this section).

(j) PRESCRIPTION DRUG PAYMENT REVIEW COMMISSION.—Part B is amended by adding at the end the following new section:

"PRESCRIPTION DRUG PAYMENT REVIEW COMMISSION

"SEC. 1847. (a)(1) The Director of the Congressional Office of Technology Assessment (in this section referred to as the 'Director' and the 'Office', respectively) shall provide for the appointment of a Prescription Drug Payment Review Commission (in this section referred to as the 'Commission'), to be composed of individuals with expertise in the provision and financing of covered outpatient drugs appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service). 42 USC 1395w-3.

"(2) The Commission shall consist of 11 individuals. Members of the Commission shall first be appointed by no later than January 1, 1989, for a term of 3 years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than 4 members expire in any one year.

"(3) The membership of the Commission shall include recognized experts in the fields of health care economics, medicine, pharmacology, pharmacy, and prescription drug reimbursement, as well as at least one individual who is a medicare beneficiary.

"(b)(1) The Commission shall submit to Congress an annual report no later than May 1 of each year, beginning with 1990, concerning methods of determining payment for covered outpatient drugs under this part. Reports.

"(2) Such report, in 1992 and thereafter, shall include, with respect to the previous year, information on—

"(A) increases in manufacturers' prices for covered outpatient drugs and in charges of pharmacists for covered outpatient drugs,

"(B) the level of utilization of covered outpatient drugs by medicare beneficiaries, and

"(C) administrative costs relating to covered outpatient drugs.

"(3) Such report, in 1992 and thereafter, shall include comments on the budgetary status of the Federal Catastrophic Drug Insurance Trust Fund and recommendations for any reductions in outlays that may be required to achieve the contingency margin (established under section 1841A(d) for the following year), taking into account each of the causes of increased or unanticipated outlays for covered outpatient drugs in the year.

"(c) Section 1845(c)(1) shall apply to the Commission in the same manner as it applies to the Physician Payment Review Commission.

"(d) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Such sums shall be payable from the Federal Catastrophic Drug Insurance Trust Fund.". Appropriation authorization.

(k) ADDITIONAL STUDIES.—

(1) HHS.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall conduct the Reports. 42 USC 1395m note.

following studies, and report to Congress on the results of each such study by the following dates:

Diseases.

(A) A study of the possibility of including drugs which have not yet been approved under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act and biological products which have not been licensed under section 351 of the Public Health Service Act but which are commonly used in the treatment of cancer or in immunosuppressive therapy and other experimental drugs and biological products as covered outpatient drugs under the medicare program, for which a report shall be made by January 1, 1990. The study under this subparagraph shall be conducted in consultation with an advisory board of consumers, experts in the fields of cancer chemotherapy and immunosuppressive therapy, representatives of pharmaceutical manufacturers, and such other individuals as the Secretary may select.

Mail.

(B) A study to evaluate the potential to use mail service pharmacies to reduce costs to the medicare program and to medicare beneficiaries, for which a report shall be made by January 1, 1990.

(C) A study of methods to improve utilization review of covered outpatient drugs, for which a report shall be made by January 1, 1993.

(D) A longitudinal study, to be conducted as a follow-up to the data collected under the survey referred to in subsection (i)(1)(A), on the use of outpatient prescription drugs by medicare beneficiaries with respect to medical necessity, potential for adverse drug interactions, cost (including whether lower cost drugs could have been used), and patient stockpiling or wastage, for which a report shall be made by January 1, 1993.

(2) GAO.—The Comptroller General shall conduct the following studies, and report to Congress on the results of each such study by not later than May 1, 1991:

(A) A study comparing average wholesale prices with actual pharmacy acquisition costs by type of pharmacy.

(B) A study to determine the overhead costs of retail pharmacies.

(C) A study of the discounts given by pharmacies to other third-party insurers.

Records.

Pharmacies which fail to provide the Comptroller General with reasonable access to necessary records to carry out the studies under this paragraph are subject to exclusion from the medicare and medicaid programs under section 1128(a) of the Social Security Act.

42 USC 1395m note.

(l) DEVELOPMENT OF STANDARD MEDICARE CLAIMS FORM.—

(1) The Secretary shall develop, in consultation with representatives of pharmacies and other interested individuals, a standard claims form (and a standard electronic claims format) to be used in requests for payment for covered outpatient drugs under the medicare program and other third-party payors.

(2) Not later than October 1, 1989, the Secretary shall distribute official sample copies of the format developed under paragraph (1) to pharmacies and other interested parties and by not later than October 1, 1990, shall distribute official sample copies of the form developed under paragraph (1) to pharmacies and other interested parties.

(m) EFFECTIVE DATES.— 42 USC 1395u note.

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to items dispensed on or after January 1, 1990.

(2) CARRIERS.—The amendments made by subsection (e) shall take effect on the date of the enactment of this Act; except that the amendments made by subsection (e)(5) shall take effect on January 1, 1991, but shall not be construed as requiring payment before February 1, 1991.

(3) HMO/CMP ENROLLMENTS.—The amendment made by subsection (f) shall apply to enrollments effected on or after January 1, 1990.

(4) DIAGNOSTIC CODING.—The amendment made by subsection (g) shall apply to services furnished after March 31, 1989.

(5) TRANSITION.—With respect to administrative expenses (and costs of the Prescription Drug Payment Review Commission) for periods before January 1, 1990, amounts otherwise payable from the Federal Catastrophic Drug Insurance Trust Fund shall be payable from the Federal Supplementary Medical Insurance Trust Fund and shall also be treated as a debit to the Medicare Catastrophic Coverage Account.

SEC. 203. COVERAGE OF HOME INTRAVENOUS DRUG THERAPY SERVICES.

(a) IN GENERAL.—Section 1832(a)(2)(A) (42 U.S.C. 1395k(a)(2)(A)) is amended by inserting "and home intravenous drug therapy services" before the semicolon.

(b) HOME INTRAVENOUS DRUG THERAPY SERVICES DEFINED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"(jj)(1) The term 'home intravenous drug therapy services' means the items and services described in paragraph (2) furnished to an individual who is under the care of a physician—

"(A) in a place of residence used as such individual's home;

"(B) by a qualified home intravenous drug therapy provider (as defined in paragraph (3)) or by others under arrangements with them made by such provider; and

"(C) under a plan established and periodically reviewed by a physician.

"(2) The items and services described in this paragraph are such nursing, pharmacy, and related services (including medical supplies, intravenous fluids, delivery, and equipment) as are necessary to conduct safely and effectively an intravenously administered drug regimen through use of a covered home IV drug (as defined in subsection (t)(4)), but do not include such covered outpatient drugs.

"(3) The term 'qualified home intravenous drug therapy provider' means any entity that the Secretary determines meets the following requirements:

"(i) The entity is capable of providing or arranging for the items and services described in paragraph (2) and covered home IV drugs.

"(ii) The entity maintains clinical records on all patients.

"(iii) The entity adheres to written protocols and policies with respect to the provision of items and services.

"(iv) The entity makes services available (as needed) seven days a week on a 24-hour basis.

"(v) The entity coordinates all services with the patient's physician.

"(vi) The entity conducts a quality assessment and assurance program, including drug regimen review and coordination of patient care.

"(vii) The entity assures that only trained personnel provide covered home IV drugs (and any other service for which training is required to safely provide the service).

"(viii) The entity assumes responsibility for the quality of services provided by others under arrangements with the agency or entity.

"(ix) In the case of an entity in any State in which State or applicable local law provides for the licensing of entities of this nature, (I) is licensed pursuant to such law, or (II) is approved, by the agency of such State or locality responsible for licensing entities of this nature, as meeting the standards established for such licensing.

"(x) The entity meets such other requirements as the Secretary may determine are necessary to assure the safe and effective provision of home intravenous drug therapy services and the efficient administration of the home intravenous drug therapy benefit.".

(c) PAYMENT.—

(1) IN GENERAL.—Part B is amended—

(A) in subsection (a)(2)(B) of section 1833 (42 U.S.C. 1395l), by striking "or (E)" and inserting "(E), or (F)";

(B) in subsection (a)(2)(D) of such section, by striking "and" at the end;

(C) in subsection (a)(2)(E) of such section, by striking the semicolon and inserting "; and";

(D) by inserting after subsection (a)(2)(E) of such section the following new subparagraph:

"(F) with respect to home intravenous drug therapy services, the amounts described in section 1834(d)(1);";

(E) in subsection (b) of such section, by striking "services, (3)" and inserting "services and home intravenous drug therapy services, (3)"; and

(F) by adding at the end of section 1834, as amended by section 202(b)(4) of this Act, the following new subsection:

42 USC 1395m. "(d) HOME INTRAVENOUS DRUG THERAPY SERVICES.—

"(1) IN GENERAL.—With respect to home intravenous drug therapy services, subject to paragraph (3), payment under this part shall be made in an amount equal to the lesser of the actual charges for such services or the fee schedule established under paragraph (2).

Regulations. "(2) ESTABLISHMENT OF FEE SCHEDULE.—The Secretary shall establish by regulation before the beginning of calendar year 1990 and each succeeding calendar year a fee schedule for home intravenous drug therapy services for which payment is made under this part. A fee schedule established under this subsection shall be on a per diem basis.

"(3) LIMITATION ON ACCEPTANCE OF, AND PAYMENTS FOR, CERTAIN REFERRALS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), a home intravenous drug therapy provider may not provide home intravenous drug therapy services under this part to an individual if the individual's referring physician (as defined in subparagraph (D)), or an immediate family member of the physician—

"(i) has an ownership interest in the provider, or
"(ii) receives compensation from the provider.

"(B) EXCEPTIONS.—

"(i) Subparagraph (A)(i) shall not apply—

"(I) if the ownership interest is the ownership of stock which is traded over a publicly-regulated exchange and was purchased on terms generally available to the public, or

"(II) if the provider is a sole home intravenous drug therapy provider (as defined by the Secretary) in a rural area.

"(ii) Subparagraph (A)(ii) shall not apply if the compensation is reasonably related to items or services actually provided by the physician and does not vary in proportion to the number of referrals made by the referring physician, but such exception shall not apply to compensation provided for direct patient care services.

"(iii) Subparagraph (A) shall not be construed to apply to a referring physician whose only ownership or financial relationship with the provider is as an uncompensated officer or director of the provider.

"(iv) Subparagraph (A) also shall not apply in such cases, established by the Secretary in regulations, in which the nature of the ownership or compensation does not pose a substantial risk of program abuse.

"(C) SANCTIONS.—

"(i) DENIAL OF PAYMENT.—No payment may be made under this part for home intravenous drug therapy services which are provided in violation of subparagraph (A).

"(ii) CIVIL MONEY PENALTY FOR IMPROPER CLAIMS.—Any person (including a home intravenous drug therapy provider or physician) that presents or causes to be presented a claim for an item or service that such person knows or should know is for an item or service for which payment may not be made under subparagraph (A) shall be subject to a civil money penalty of not more than $15,000 for each such item or service. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(D) REFERRING PHYSICIAN DEFINED.—In this paragraph, the term 'referring physician' means, with respect to providing home intravenous drug therapy services to an individual, a physician who—

"(i) prescribed the covered home IV drug for which the services are to be provided, or

"(ii) established the plan of care for such services.".

(2) PROPAC STUDY.—The Prospective Payment Assessment Commission shall conduct a study, and make recommendations to Congress and the Secretary of Health and Human Services by not later than March 1, 1991, concerning appropriate adjustment to the payment amounts provided under section 1886(d) of the Social Security Act for inpatient hospital services to account

42 USC 1395ww note.

for reduced costs to hospitals resulting from the amendments made by this section.

Health care professionals.

(3) INSPECTOR GENERAL REPORT ON POTENTIALLY ABUSIVE OWNERSHIP OR COMPENSATION ARRANGEMENTS.—The Inspector General of the Department of Health and Human Services shall study and report to Congress, by not later than May 1, 1989, concerning—

(A) physician ownership of, or compensation from, an entity providing items or services to which the physician makes referrals and for which payment may be made under the medicare program;

(B) the range of such arrangements and the means by which they are marketed to physicians;

(C) the potential of such ownership or compensation to influence the decision of a physician regarding referrals and to lead to inappropriate utilization of such items and services; and

Law enforcement and crime.

(D) the practical difficulties involved in enforcement actions against such ownership and compensation arrangements that violate current antikickback provisions.

Such report shall include such recommendations as may be appropriate to strengthen current law provisions to prevent program abuse.

(d) CERTIFICATION.—

(1) IN GENERAL.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)) is amended—

(A) by striking "and" at the end of subparagraph (E);

(B) by striking the period at the end of subparagraph (F) and inserting "; and"; and

(C) by inserting after subparagraph (F) the following new subparagraph:

"(G) in the case of home intravenous drug therapy services, (i) such services are or were required because the individual needed such services for the administration of a covered home IV drug, (ii) a plan for furnishing such services has been established and is reviewed periodically by a physician, (iii) such services are or were furnished while the individual is or was under the care of a physician, (iv) such services are administered in a place of residence used as such individual's home, and (v) with respect to such services initiated before January 1, 1993, such services have been reviewed and approved by a utilization and peer review organization under section 1154(a)(16) before the date such services were initiated (or, in the case of services first initiated on an outpatient basis, within 1 working day (except in exceptional circumstances) of the date of initiation of the services).".

(2) PRO PRIOR APPROVAL REQUIRED.—Section 1154(a) (42 U.S.C. 1320c-3(a)) is amended by adding at the end the following new paragraph:

"(16) The organization shall perform the review described in paragraph (1) with respect to home intravenous drug therapy services (as defined in section 1861(jj)(1)) initiated before January 1, 1993, within 1 working day of the date of the organization's receipt of a request for such review. The Secretary shall establish criteria to be used by such an organization in conduct-

ing reviews with respect to the appropriateness of home intravenous drug therapy services under this paragraph.".

(e) CERTIFICATION OF HOME INTRAVENOUS DRUG THERAPY PROVIDERS; INTERMEDIATE SANCTIONS FOR NONCOMPLIANCE.—

(1) TREATMENT AS PROVIDER OF SERVICES.—Section 1861(u) (42 U.S.C. 1395x(u)) is amended by inserting "home intravenous drug therapy provider," after "hospice program,".

(2) CONSULTATION WITH STATE AGENCIES AND OTHER ORGANIZATIONS.—Section 1863 (42 U.S.C. 1395z) is amended by striking "and (dd)(2)" and inserting "(dd)(2), and (jj)(3)".

(3) USE OF STATE AGENCIES IN DETERMINING COMPLIANCE.—Section 1864(a) (42 U.S.C. 1395aa(a)) is amended—

(A) in the first sentence, by inserting "or a home intravenous drug therapy provider," after "hospice program", and

(B) in the second sentence, by striking "or hospice program" and inserting "hospice program, or home intravenous drug therapy provider".

(4) APPLICATION OF INTERMEDIATE SANCTIONS.—Section 1846 (42 U.S.C. 1395w-2) is amended—

(A) in the heading, by adding "AND FOR QUALIFIED HOME INTRAVENOUS DRUG THERAPY PROVIDERS" at the end;

(B) in subsection (a), by inserting "or that a qualified home intravenous drug therapy provider that is certified for participation under this title no longer substantially meets the requirements of section 1861(jj)(3)" after "under this part"; and

(C) in subsection (b)(2)(A)(iv) by inserting "or home intravenous drug therapy services" after "clinical diagnostic laboratory tests".

(f) USE OF REGIONAL INTERMEDIARIES IN ADMINISTRATION OF BENEFIT.—Section 1816 (42 U.S.C. 1395h) is amended by adding at the end thereof the following new subsection:

"(k) With respect to carrying out functions relating to payment for home intravenous drug therapy services and covered home IV drugs, the Secretary may enter into contracts with agencies or organizations under this section to perform such functions on a regional basis.". Contracts.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1990. 42 USC 1320c-3 note.

SEC. 204. COVERAGE OF SCREENING MAMMOGRAPHY.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) is amended—

(1) in subsection (s)—

(A) by redesignating paragraphs (13) and (14) as paragraphs (14) and (15), respectively,

(B) by striking "and" at the end of paragraph (11),

(C) by striking the period at the end of paragraph (12) and inserting "; and", and

(D) by inserting after paragraph (12) the following new paragraph:

"(13) screening mammography (as defined in subsection (kk))."; and

(2) by adding at the end the following new subsection:

"Screening Mammography

"(kk) The term 'screening mammography' means a radiologic procedure provided to a woman for the purpose of early detection of breast cancer and includes a physician's interpretation of the results of the procedure.".

(b) PAYMENT AND COVERAGE.—Section 1834 (42 U.S.C. 1395m), as amended by sections 202(b)(4) and 203(c)(1)(F) of this Act, is amended—

(1) in subsection (b)(1)(B), by inserting "and subject to subsection (e)(1)(A)" after "conversion factors", and

(2) by adding at the end the following new subsection:

"(e) PAYMENTS AND STANDARDS FOR SCREENING MAMMOGRAPHY.—

"(1) IN GENERAL.—Notwithstanding any other provision of this part (except as provided in section 1833(c)), with respect to expenses incurred for screening mammography (as defined in section 1861(kk))—

"(A) payment may be made only for screening mammography conducted consistent with the frequency permitted under paragraph (2);

"(B) payment may be made only if the screening mammography meets the quality standards established under paragraph (3); and

"(C) the amount of the payment under this part shall, subject to the deductible established under section 1833(b), be equal to 80 percent of the least of—

"(i) the actual charge for the screening,

"(ii) the fee schedule established under subsection (b) with respect to both the professional and technical components of the screening mammography, in the case of screening mammography subject to such schedule but for this paragraph, or

"(iii) the limit established under paragraph (4) for the screening mammography.

"(2) FREQUENCY COVERED.—

"(A) IN GENERAL.—Subject to revision by the Secretary under subparagraph (B)—

"(i) No payment may be made under this part for screening mammography performed on a woman under 35 years of age.

"(ii) Payment may be made under this part for only 1 screening mammography performed on a woman over 34 years of age, but under 40 years of age.

"(iii) In the case of a woman over 39 years of age, but under 50 years of age, who—

"(I) is at a high risk of developing breast cancer (as determined pursuant to factors identified by the Secretary), payment may not be made under this part for a screening mammography performed within the 11 months of a previous screening mammography, or

"(II) is not at a high risk of developing breast cancer, payment may not be made under this part for a screening mammography performed within the 23 months after a previous screening mammography.

"(iv) In the case of a woman over 49 years of age, but under 65 years of age, payment may not be made under this part for screening mammography performed within 11 months after a previous screening mammography.

"(v) In the case of a woman over 64 years of age, payment may not be made for screening mammography performed within 23 months after a previous screening mammography.

"(B) REVISION OF FREQUENCY.—

"(i) REVIEW.—The Secretary, in consultation with the Director of the National Cancer Institute, shall review periodically the appropriate frequency for performing screening mammography, based on age and such other factors as the Secretary believes to be pertinent.

"(ii) REVISION OF FREQUENCY.—The Secretary, taking into consideration the review made under clause (i), may revise from time to time the frequency with which screening mammography may be paid for under this subsection, but no such revision shall apply to screening mammography performed before January 1, 1992.

"(3) QUALITY STANDARDS.—The Secretary shall establish standards to assure the safety and accuracy of screening mammography performed under this part. Such standards shall include the requirements that— Safety.

"(A) the equipment used to perform the mammography must be specifically designed for mammography and must meet radiologic standards established by the Secretary for mammography;

"(B) the mammography must be performed by an individual who—

"(i) is licensed by a State to perform radiological procedures, or

"(ii) is certified as qualified to perform radiological procedures by such an appropriate organization as the Secretary specifies in regulations;

"(C) the results of the mammography must be interpreted by a physician—

"(i) who is certified as qualified to interpret radiological procedures by such an appropriate board as the Secretary specifies in regulations, or

"(ii) who is certified as qualified to interpret screening mammography procedures by such a program as the Secretary recognizes in regulation as assuring the qualifications of the individual with respect to such interpretation; and

"(D) with respect to the first screening mammography performed on a woman for which payment is made under this part, there are satisfactory assurances that the results of the mammography will be placed in permanent medical records maintained with respect to the woman. Records.

"(4) LIMIT.—

"(A) $50, INDEXED.—Except as provided by the Secretary under subparagraph (B), the limit established under this paragraph—

"(i) for screening mammography performed in 1990, is $50, and

"(ii) for screening mammography performed in a subsequent year is the limit established under this paragraph for the preceding year increased by the percentage increase in the MEI for that subsequent year.

"(B) REDUCTION OF LIMIT.—The Secretary shall review from time to time the appropriateness of the amount of the limit established under this paragraph. The Secretary may, with respect to screening mammography performed in a year after 1991, reduce the amount of such limit as it applies nationally or in any area to the amount that the Secretary estimates is required to assure that screening mammography of an appropriate quality is readily and conveniently available during the year.

Claims.

"(C) APPLICATION OF LIMIT IN HOSPITAL OUTPATIENT SETTING.—The Secretary shall provide for an appropriate allocation of the limit established under this paragraph between professional and technical components in the case of hospital outpatient screening mammography (and comparable situations) where there is a claim for professicnal services separate from the claim for the radiologic procedure.

"(5) LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS.—

"(A) IN GENERAL.—In the case of mammography screening performed on or after January 1, 1990, for which payment is made under this subsection, if a nonparticipating physician or supplier provides the screening to an individual entitled to benefits under this part, the physician or supplier may not charge the individual more than the limiting charge (as defined in subparagraph (B), or, if applicable and if less, as defined in subsection (b)(5)(B)).

"(B) LIMITING CHARGE DEFINED.—In subparagraph (A), the term 'limiting charge' means, with respect to screening mammography performed—

"(i) in 1990, 125 percent of the limit established under paragraph (4),

"(ii) in 1991, 120 percent of the limit established under paragraph (4), and

"(iii) after 1991, 115 percent of the limit established under paragraph (4).

"(C) ENFORCEMENT.—If a physician or supplier knowing and willfully imposes a charge in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2).".

(c) CERTIFICATION OF SCREENING MAMMOGRAPHY QUALITY STANDARDS.—

(1) Section 1863 (42 U.S.C. 1395z) is amended by inserting "or whether screening mammography meets the standards established under section 1834(e)(3)," after "1832(a)(2)(F)(i),".

(2) The first sentence of section 1864(a) (42 U.S.C. 1395aa(a)) is amended by inserting before the period the following: ", or whether screening mammography meets the standards established under section 1834(e)(3)".

(3) Section 1865(a) (42 U.S.C. 1395bb(a)) is amended by inserting "1834(e)(3)," after "1832(a)(2)(F)(i),".

(d) CONFORMING AMENDMENTS.—

(1) Section 1833(a)(2)(E) (42 U.S.C. 1395l(a)(2)(E)) is amended by inserting ", but excluding screening mammography" after "imaging services".

(2) Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (A), by striking "subparagraph (B), (C), (D), or (E)" and inserting "a succeeding subparagraph",

(ii) in subparagraph (D), by striking "and" at the end,

(iii) in subparagraph (E), by striking the semicolon at the end and inserting ", and", and

(iv) by adding at the end the following new subparagraph:

"(F) in the case of screening mammography, which is performed more frequently than is covered under section 1834(e)(2) or which does not meet the standards established under section 1834(e)(3);"; and

(B) in paragraph (7), by inserting "or under paragraph (1)(F)" after "(1)(B)".

(3) Sections 1864(a), 1865(a), 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) (42 U.S.C. 1395aa(a), 1395bb(a), 1396a(a)(9)(C), 1396n(a)(1)(B)(ii)(I)) are each amended by striking "paragraphs (13) and (14)" and inserting "paragraphs (14) and (15)".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to screening mammography performed on or after January 1, 1990. Paragraph (5) of section 1834(e) of the Social Security Act shall only apply until such time as the Secretary of Health and Human Services implements the physician fee schedules based on relative value scale developed under section 1845(e) of such Act. 42 USC 1395m note.

(f) REPORTS.— 42 USC 1395m note.

(1) The Physician Payment Review Commission shall study and report, by July 1, 1989, to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate concerning the cost of providing screening mammography in a variety of settings and at different volume levels.

(2) The Comptroller General shall study and report, by July 1, 1989, to the Committees specified in paragraph (1) concerning the quality of care of screening mammography in a variety of settings.

SEC. 205. IN-HOME CARE FOR CERTAIN CHRONICALLY DEPENDENT INDIVIDUALS.

(a) IN GENERAL.—Section 1832(a) (42 U.S.C. 1395k(a)) is amended—

(1) in paragraph (2)(A)—

(A) by inserting "(i)" after "(A)", and

(B) by inserting before the semicolon at the end the following: ", and (ii) in-home care for a chronically dependent individual for up to 80 hours in any 12-month period described in section 1861(ll)(4), but not to exceed 80 hours in any calendar year;"; and

(2) by adding at the end the following new sentence:

"In the case of in-home care (described in paragraph (2)(A)(ii)) provided to a chronically dependent individual on any day, such care provided for 3 hours or less on the day shall be counted (for purposes of the limitation in such paragraph) as 3 hours of such care.".

(b) IN-HOME CARE FOR CHRONICALLY DEPENDENT INDIVIDUAL DEFINED.—Section 1861 (42 U.S.C. 1395x), as amended by section 204(a)(2) of this Act, is amended by adding at the end the following new subsection:

"In-Home Care; Chronically Dependent Individual

"(ll)(1) The term 'in-home care' means the following items and services furnished, under the supervision of a registered professional nurse, to a chronically dependent individual (as defined in paragraph (2)) during the period described in paragraph (4) by a home health agency or by others under arrangements with them made by such agency in a place of residence used as such individual's home:

"(A) Services of a homemaker/home health aide (who has successfully completed a training program approved by the Secretary).

"(B) Personal care services.

"(C) Nursing care provided by a licensed professional nurse.

"(2) The term 'chronically dependent individual' means an individual who—

"(A) is dependent on a daily basis on a primary caregiver who is living with the individual and is assisting the individual without monetary compensation in the performance of at least 2 of the activities of daily living (described in paragraph (3)), and

"(B) without such assistance could not perform such activities of daily living.

"(3) The 'activities of daily living', referred to in paragraph (2), are as follows:

"(i) Eating.

"(ii) Bathing.

"(iii) Dressing.

"(iv) Toileting.

"(v) Transferring in and out of a bed or in and out of a chair.

"(4) The 12-month period described in this paragraph is the 1-year period beginning on the date that the Secretary determines that a chronically dependent individual either—

"(A) has become entitled to benefits under section 1833(c) (relating to having incurred out-of-pocket part B cost sharing equal to the part B catastrophic limit), or

"(B) has become entitled to have payments made for covered outpatient drugs under section 1834(c).

In the case of an individual who qualifies under subparagraph (A) or (B) within 12 months after previously qualifying, the subsequent qualification shall begin a new 12-month period under this paragraph. In the case of an individual enrolled in a buy-out plan (as defined in section 1833(c)(5)(D)) or a drug buy-out plan (as defined in section 1834(c)(6)(D)), the Secretary shall establish such procedures as may be appropriate to identify individuals who are deemed to be described in subparagraph (A) or (B), respectively, for purposes of the provision of in-home care under the plan.".

(c) PAYMENT.—Section 1833(a) (42 U.S.C. 1395l(a)) is amended—

(1) in paragraph (2), by inserting "(A)(ii)," after "subparagraphs" the first place it appears,

(2) in paragraph (3), by striking "(D)" and inserting "(A)(ii), (D),", and

(3) by adding at the end the following:

"Payment for in-home care for chronically dependent individuals shall be paid on the basis of an hour of such care provided. In applying paragraph (2) in the case of an organization receiving payment under clause (A) of paragraph (1) or under a reasonable cost reimbursement contract under section 1876 and providing coverage of in-home care, the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect the aggregate increase in payments that would otherwise be made with respect to enrollees in the organization if payments were made other than under such clause or such a contract if payments were to be made on an individual-by-individual basis.". Contracts.

(d) CERTIFICATION.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)), as amended by section 203(d) of this Act, is amended—

(1) by striking "and" at the end of subparagraph (F);

(2) by striking the period at the end of subparagraph (G) and inserting in lieu thereof "; and"; and

(3) by inserting after subparagraph (G) the following new subparagraph:

"(H) in the case of in-home care provided to a chronically dependent individual during a 12-month period, the individual was a chronically dependent individual during the 3-month period immediately preceding the beginning of the 12-month period.".

(e) STANDARDS FOR UTILIZATION.—

(1) Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 204(d)(2) of this Act, is amended—

(A) in paragraph (1)—

(i) by striking "and" at the end of subparagraph (E),

(ii) by adding "and" at the end of subparagraph (F), and

(iv) by adding at the end the following new subparagraph:

"(G) in the case of in-home care for chronically dependent individuals, which is not reasonable and necessary to assure the health and condition of the individual is maintained in the individual's noninstitutional residence;"; and

(B) in paragraph (6), by inserting "and except, in the case of in-home care, as is otherwise permitted under paragraph (1)(G)" after "paragraph (1)(C)".

(2) The Secretary of Health and Human Services shall take appropriate efforts to assure the quality, and provide for appropriate utilization of, in-home care for chronically dependent individuals under the amendments made by this section. 42 USC 1395k note.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1990. 42 USC 1395k note.

(g) STUDY OF ALTERNATIVE OUT-OF-HOME SERVICES.—The Secretary of Health and Human Services shall study, and report to Congress, not later than 18 months after the date of the enactment of this Act, on the advisability of providing, to chronically dependent individuals eligible for in-home care under the amendments made by this section, out-of-home services (such as adult day care services or nursing facility services) as alternative services to in-home care. Reports. 42 USC 1395k note.

SEC. 206. EXTENDING HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1861(m) (42 U.S.C. 1395x(m)) is amended by adding at the end the following new sentence: "For purposes of paragraphs (1) and (4) and sections 1814(a)(2)(C) and 1835(a)(2)(A),

nursing care and home health aide services shall be considered to be provided or needed on an 'intermittent' basis if they are provided or needed less than 7 days each week and, in the case they are provided or needed for 7 days each week, if they are provided or needed for a period of up to 38 consecutive days.".

42 USC 1395x note.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished in cases of initial periods of home health services beginning on or after January 1, 1990.

42 USC 1395b-1 note.

SEC. 207. RESEARCH ON LONG-TERM CARE SERVICES FOR MEDICARE BENEFICIARIES.

(a) IN GENERAL.—The Secretary of Health and Human Services, from the funds appropriated under subsection (b), shall provide for research on issues relating to the delivery and financing of long-term care services for medicare beneficiaries. Such research shall include research into at least the following areas:

(1) The financial characteristics of medicare beneficiaries who receive or need long-term care services, including whether such beneficiaries are eligible for medicaid benefits for such services.

(2) How the financial and other characteristics of medicare beneficiaries affect their utilization of institutional and noninstitutional long-term care services.

(3) How relatives of medicare beneficiaries are affected financially and in other ways because the beneficiaries require or receive long-term care services.

(4) The quality of long-term care services (in community-based and custodial settings) and how the provision of long-term care services may reduce expenditures for acute health care services.

Consumer protection.

(5) The effectiveness of, and need for, State and Federal consumer protections which assure adequate access to and protect the rights of medicare beneficiaries who are provided long-term care services (other than in a nursing facility).

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, in equal parts from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, $5,000,000 for each of fiscal years 1989, 1990, 1991, 1992, and 1993 to carry out the research described in subsection (a).

(c) LONG-TERM CARE SERVICES DEFINED.—In this section, the term "long-term care services" includes nursing home care, home care, community-based services, and custodial care.

(d) REPORTS.—The Secretary of Health and Human Services shall submit interim reports by December 1, 1990, and by December 1, 1992, and a final report by June 1, 1994, concerning the demonstration projects conducted under this section.

42 USC 1395ll note.

SEC. 208. STUDY OF ADULT DAY CARE SERVICES.

(a) SURVEY OF CURRENT ADULT DAY CARE SERVICES.—The Secretary of Health and Human Services shall conduct a survey of adult day care services in the United States to collect information concerning—

(1) the scope of such services and the extent of their availability;

(2) the characteristics of entities providing such services;

(3) licensure, certification, and other quality standards that are applied to those providing such services;

(4) the cost and financing of such services; and

(5) the characteristics of the people who use such services.

(b) REPORT.—The Secretary shall report to Congress, by not later than 1 year after the date of the enactment of this Act, on the information collected in the survey. Based on such information, the Secretary shall include in the report recommendations concerning appropriate standards for coverage of adult day care services under medicare, including defining chronically dependent individuals, defining services included in adult day care services, establishing qualifications of providers of adult day care services, and establishing a reimbursement mechanism.

(c) ADULT DAY CARE SERVICES DEFINED.—In this section, the term "adult day care services" means medical or social services provided in an organized nonresidential setting to chronically impaired individuals who are not inpatients in a medical institution.

Subtitle B—Medicare Part B Monthly Premium Financing

SEC. 211. ADJUSTMENT IN MEDICARE PART B PREMIUM.

Prescription drugs.

(a) IN GENERAL.—Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following new subsection:

"(g)(1)(A) Except as provided in this paragraph, paragraphs (4) and (5), and subsections (b) and (f), the monthly premium for each individual enrolled under this part otherwise determined, without regard to this subsection, shall be increased by the sum of the catastrophic coverage monthly premium and the prescription drug monthly premium for months in the year determined under the following table (for months occurring in 1989 through 1993) or determined in accordance with paragraphs (2) and (3) (for months after December 1993):

"In the case of:	The catastrophic coverage monthly premium is:	The prescription drug monthly premium is:
1989	$4.00	0
1990	$4.90	0
1991	$5.46	$1.94
1992	$6.75	$2.45
1993	$7.18	$3.02.

"(B)(i) Except as provided in subparagraph (C), if the amount of the supplemental premium rate otherwise determined under section 59B of the Internal Revenue Code of 1986 for taxable years beginning in a calendar year is increased as a result of subsection (e)(2)(A)(i) of such section or is reduced as a result of subsection (e)(2)(A)(ii) of such section, the monthly premium increase otherwise determined under this paragraph shall be reduced or increased, respectively, by an amount equal to—

"(I) 1/12th of the excess or shortfall, respectively, determined under clause (ii) for the year, as adjusted under clause (iv), divided by

"(II) the average number of individuals covered under this part during the preceding year.

"(ii) The excess or shortfall determined under this clause for a year is the excess or shortfall, determined by the Secretary of the Treasury, of—

"(I) the total amount of the supplemental premiums imposed under section 59B of the Internal Revenue Code of 1986 in the 2nd preceding year, over

"(II) the total amount of such premiums which would have been imposed in such year if the supplemental premium rate under such section had been increased by the shortfall rate, or decreased by the excess rate, described in clause (iii).

"(iii) The excess rate or shortfall rate under this clause for a year is the excess or shortfall of—

"(I) the supplemental premium rate established under section 59B of the Internal Revenue Code of 1986 for taxable years beginning in the year, and

"(II) the amount of such supplemental rate if determined without regard to subsection (e)(2)(A) of such section.

"(iv) The amount determined under clause (i)(I) for a year shall be increased by the percentage by which the per capita catastrophic coverage premium liability (as determined in section 59B(e)(3)(D)(ii) of the Internal Revenue Code of 1986) for the second preceding year exceeds such liability for the fourth preceding year (determined as if the catastrophic coverage premium rate for the second preceding calendar year were the same as the rate in effect for the fourth preceding calendar year).

"(C) In no event shall the monthly premium increase in effect under this paragraph for months in a year after 1993 be less than the monthly premium increase in effect under this paragraph for months in the preceding year.

"(D) If subparagraph (B) or subparagraph (C), or both, affects the increase in the monthly premium determined under this paragraph for a year, the increase in the monthly premium determined after the application of such subparagraph or subparagraphs shall be allocated between the catastrophic coverage monthly premium and the prescription drug monthly premium on the basis of the respective amounts of such premiums without regard to the application of either such subparagraph.

"(2)(A) In the case of months in a year after 1993, the catastrophic coverage monthly premium is the catastrophic coverage monthly premium (in effect under paragraph (1) or this paragraph for months in the preceding year, determined without regard to paragraph (1)(B) or (1)(C)) adjusted by the percentage determined under subparagraph (B) for the year.

"(B) The percentage determined under this subparagraph for a year shall be the sum of—

"(i) the outlay-premium percentage, and

"(ii) the reserve account percentage.

For purposes of the preceding sentence, negative percentages shall be taken into account as negatives.

"(C)(i) Except as provided in clause (ii), the outlay-premium percentage for any year is the percentage by which—

"(I) the per capita catastrophic outlays in the 2nd preceding year exceeds

"(II) such outlays in the 3rd preceding calendar year.

If there is no excess, this clause shall be applied by substituting 'is less than' for 'exceeds' and the percentage determined with such substitution shall be taken into account as a negative percentage.

"(ii) If—

"(I) the percentage increase in the CPI for the 12-month period ending with May of the preceding calendar year, exceeds (or is less than)

"(II) such increase for the 12-month period ending with May of the 2nd preceding calendar year,

by at least 1 percentage point, the percentage determined under clause (i) for any year shall be adjusted up (or down, respectively) by ½ of the amount by which such excess (or shortage, respectively) exceeds 1 percent.

"(D)(i) The reserve account percentage for any calendar year is the percentage which the premium change determined under clause (ii) is of the catastrophic coverage monthly premium in effect under paragraph (1) or this paragraph for the preceding year (determined without regard to paragraph (1)(B) or (1)(C)). If there is an excess determined under clause (iii), the percentage determined under the preceding sentence shall be taken into account as a negative percentage.

"(ii) The premium change determined under this clause for any year is the adjustment in the catastrophic coverage monthly premium (otherwise in effect for the 2nd preceding year) which the Secretary determines would have resulted in an aggregate increase (or decrease) in the premiums imposed by this subsection for such year equal to 37 percent of the shortfall or excess determined under clause (iii) for the calendar year.

"(iii) The shortfall (or excess) determined under this clause for any year is the amount by which—

"(I) 20 percent of the outlays during the 2nd preceding calendar year from the Medicare Catastrophic Coverage Account created under section 1841B, exceeds (or is less than)

"(II) the balance in such Account as of the close of such 2nd preceding calendar year (determined by taking into account previous premium increases by reason of the reserve account percentage under this paragraph or section 59B(e) of the Internal Revenue Code of 1986 which have not been credited into such Account).

"(3) In the case of months in a year after 1993, the prescription drug monthly premium shall be determined under rules similar to the rules of paragraph (2); except that—

"(A) in determining the prescription drug monthly premium for any month in a year before 1998, the following percentages shall be substituted for 20 percent in paragraph (2)(D)(iii)(I):

"In the case of year:	The percentage is:
1994	75
1995	50
1996	25
1997	25;

"(B) no adjustment by reason of the outlay-premium percentage shall be made for any calendar year before 1998;

"(C) any reference to the Medicare Catastrophic Coverage Account shall be treated as a reference to the Federal Catastrophic Drug Insurance Trust Fund; and

"(D) any reference to the catastrophic coverage monthly premium shall be treated as a reference to the prescription drug monthly premium.

"(4)(A) In the case of an individual who is a resident of Puerto Rico or who is a resident of another U.S. commonwealth or territory during a month, instead of the premium increase provided under

Territories, U.S.

paragraph (1), subject to subsection (b), the monthly premium for each individual enrolled under this part otherwise determined, without regard to this subsection, shall be increased by the sum of—

"(i) the catastrophic coverage monthly premium determined under subparagraph (B) for such resident for the year, and

"(ii) the prescription drug monthly premium determined under subparagraph (C) for the resident for the year.

"(B) The catastrophic coverage monthly premium for months—

"(i) in 1989 is $1.30 for a resident of Puerto Rico and $2.10 for a resident of another U.S. commonwealth or territory;

"(ii) in 1990 is $3.56 for a resident of Puerto Rico and $5.78 for a resident of another U.S. commonwealth or territory; and

"(iii) in a subsequent year, with respect to a resident of Puerto Rico or a resident of another U.S. commonwealth or territory, is the catastrophic coverage monthly premium established under this subparagraph for the preceding year with respect to such a resident increased by the same percentage (estimated by the Secretary in September of that preceding year) by which—

"(I) the per capita catastrophic outlays for the year, will exceed

"(II) the per capita catastrophic outlays for that preceding year.

"(C) The prescription drug monthly premium for months—

"(i) in 1990 is $0.14 for a resident of Puerto Rico and $0.22 for a resident of another U.S. commonwealth or territory;

"(ii) in 1991 is $1.21 for a resident of Puerto Rico and $1.93 for a resident of another U.S. commonwealth or territory; and

"(iii) in a subsequent year, with respect to a resident of Puerto Rico or a resident of another U.S. commonwealth or territory, is the prescription drug monthly premium established under this subparagraph for the preceding year with respect to such a resident increased by the same percentage (estimated by the Secretary in September of that preceding year) by which—

"(I) the per capita prescription drug outlays for the year, will exceed

"(II) the per capita prescription drug outlays for that preceding year.

"(5)(A) In the case of a part B only individual (as defined in paragraph (8)(F)) during a month, instead of the premium increase provided under paragraph (1), subject to subsection (b), the monthly premium otherwise determined, without regard to this subsection, shall be increased by the sum of—

"(i) the catastrophic coverage monthly premium determined under subparagraph (B) for the year, and

"(ii) the prescription drug monthly premium determined under subparagraph (C) for the year.

"(B) The catastrophic coverage monthly premium for months—

"(i) in 1990 is $8.57, and

"(ii) in a subsequent year is 1/12th of the average actuarial expenses that the Secretary estimates (during September before the year) will be incurred during the year for benefits and administration costs (other than benefits and costs attributable to part A) for which outlays may be made from the Medicare Catastrophic Coverage Account.

"(C) The prescription drug monthly premium for months—

"(i) in 1990 is $0.53,

"(ii) in 1991 is $4.61, and

"(iii) a subsequent year is 1/12th of the average actuarial expenses that the Secretary estimates (during September before the year) will be incurred during the year for benefits and administration costs for which outlays may be made from the Federal Catastrophic Drug Insurance Trust Fund.

"(6)(A) If any premium increase for a month under this subsection is not a multiple of 10 cents, the Secretary shall round the increase to the nearest multiple of 10 cents.

"(B) If the Secretary so rounds the premium increase, the amount of such increase shall be allocated between the catastrophic coverage monthly premium and the prescription drug monthly premium on the basis of the respective amounts of such premiums without regard to the application of subparagraph (A).

"(7)(A) The Secretary and the Secretary of the Treasury shall jointly—

"(i) publish in the Federal Register by not later than July 1 of each year (beginning with 1993) a proposed regulation to establish premium increases under this subsection for months in the following year, Federal Register, publication. Regulations.

"(ii) report to Congress, by not later than September 1 of such year, on the final premiums to be published under clause (iii), and Reports.

"(iii) publish in the Federal Register, during the last 3 days of September of each such year, a final regulation establishing monthly premiums under this subsection for months in the following year. Federal Register, publication. Regulations.

"(B) The Secretary shall report to Congress, in 1993, respecting the appropriateness of the level of premium increases established under paragraph (4) for residents of Puerto Rico and of other U.S. commonwealths and territories. Reports. Territories, U.S.

"(8) For purposes of this subsection:

"(A) The term 'per capita catastrophic outlays' means, with respect to any year, the amount (as determined by the Secretary) equal to—

"(i) the outlays during such year from the Medicare Catastrophic Coverage Account, divided by

"(ii) the average number of individuals entitled to receive benefits under part A during such year.

"(B) The term 'per capita prescription drug outlays' means, with respect to any year, the amount (as determined by the Secretary) equal to—

"(i) the outlays during such year from the Federal Catastrophic Drug Insurance Trust Fund, divided by

"(ii) the average number of individuals entitled to receive benefits under part A during such year.

"(C) The percentage increase in the CPI for any 12-month period shall be the percentage by which the Consumer Price Index (as defined in section 1(f)(5) of the Internal Revenue Code of 1986) for the last month of such period exceeds such Index for the last month of the preceding 12-month period.

"(D) The term 'Medicare Catastrophic Coverage Account' refers to such Account as created under section 1841B.

"(E) The term 'U.S. commonwealth or territory' means Puerto Rico, the United States Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands.

"(F) The term 'part B only individual' means, with respect to a month, an individual who—

"(i) is not a resident of a U.S. commonwealth or territory (as defined in subparagraph (E)) during the month,

"(ii) is entitled to benefits under this part, and

"(iii) is not entitled to (or, on application without payment of an additional premium, would not be entitled to) benefits under part A or is entitled to benefits under such part only because of payment of a premium under section 1818.".

(b) EXTENSION OF HOLD-HARMLESS PROVISION.—Subsection (f) of section 1839 (42 U.S.C. 1395r) is amended to read as follows:

"(f) For any calendar year after 1988, if an individual is entitled to monthly benefits under section 202 or 223 or to a monthly annuity under section 3(a), 4(a), or 4(f) of the Railroad Retirement Act of 1974 for November and December of the preceding year, and if the monthly premium of the individual under this section for December and for January is deducted from those benefits under section 1840(a)(1) or section 1840(b)(1), the monthly premium otherwise determined under this section for an individual for that year shall not be increased, pursuant to this subsection, to the extent that such increase would reduce the amount of benefits payable to that individual for that January below the amount of benefits payable to that individual for that December (after the deduction of the premium under this section). For purposes of this subsection, retroactive adjustments or payments and deductions on account of work shall not be taken into account in determining the monthly benefits to which an individual is entitled under section 202 or 223 or under the Railroad Retirement Act of 1974.".

(c) CONFORMING AMENDMENTS.—

(1) Section 1839 (42 U.S.C. 1395r) is amended—

(A) in the second sentence of subsections (a)(1) and (a)(4), by inserting "(other than costs relating to the amendments made by the Medicare Catastrophic Coverage Act of 1988)" before the period;

(B) by inserting before the period at the end of the last sentence of subsections (a)(1) and (a)(4) the following: ", but shall not take into account any amounts in the Trust Fund that may be attributable to receipts or outlays relating to the Medicare Catastrophic Coverage Account";

(C) in subsection (a)(2), by striking "and (e)" and inserting ", (e), and (g)";

(D) in subsection (a)(3), by striking "subsection (e)" and inserting "subsections (e) and (g)";

(E) in subsection (b), by striking "determined under subsection (a) or (e)" and inserting "otherwise determined under this section (without regard to subsections (f) and (g)(6))"; and

(F) in subsection (e)(1), by inserting "except as provided in subsection (g)," after "subsection (a)".

(2) Section 1844(a) (42 U.S.C. 1395w(a)) is amended by adding at the end the following:

"In computing the amount of aggregate premiums and premiums per enrollee under paragraph (1), there shall not be taken into account premiums attributable to section 1839(g) or section 59B of the Internal Revenue Code of 1986.".

42 USC 1395mm.

(3) Section 1876(a)(5) (42 U.S.C. 1395ff(a)(5)) is amended—

(A) by striking "and the Federal Supplementary Medical Insurance Trust Fund" and inserting ", the Federal Supple-

mentary Medical Insurance Trust Fund, and the Federal Catastrophic Drug Insurance Trust Fund", and

(B) by amending the second sentence to read as follows: "The portion of that payment to the organization for a month to be paid by each trust fund shall be determined as follows: Contracts.

"(A) In regard to expenditures by eligible organizations having risk-sharing contracts, the allocation shall be determined each year by the Secretary based on the relative weight that benefits from each fund contribute to the adjusted average per capita cost.

"(B) In regard to expenditures by eligible organizations operating under a reasonable cost reimbursement contract, the initial allocation shall be based on the plan's most recent budget, such allocation to be adjusted, as needed, after cost settlement to reflect the distribution of actual expenditures.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply (except as otherwise specified in such amendments) to monthly premiums for months beginning with January 1989. 42 USC 1395r note.

SEC. 212. ESTABLISHMENT OF FEDERAL CATASTROPHIC DRUG INSURANCE TRUST FUND; FUND TRANSFERS.

(a) IN GENERAL.—Part B of title XVIII is amended by inserting after section 1841 the following new section:

"FEDERAL CATASTROPHIC DRUG INSURANCE TRUST FUND

"SEC. 1841A. (a)(1) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Catastrophic Drug Insurance Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1) and amounts transferred to it in accordance with section 1841(j) or under paragraph (2). 42 USC 1395t-1.

"(2) There are hereby appropriated to the Trust Fund amounts equivalent to 100 percent of the supplemental premiums imposed by section 59B of the Internal Revenue Code of 1986 which are attributable to the prescription drug rate. The amounts appropriated by the preceding sentence shall be transferred from time to time (not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the premiums, specified in the preceding sentence, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the premiums specified in such sentence. At the close of each year, the transfers under this subsection shall reflect all premiums paid or deposited (as specified in this subsection) into the Treasury in the year.

"(b) The provisions of subsections (b) through (i) of section 1841 shall apply to the Trust Fund in the same manner as they apply to the Federal Supplementary Medical Insurance Trust Fund.

"(c) Notwithstanding any other provision of this title, all payments under this part on or after January 1, 1990, for benefits and administrative costs relating to covered outpatient drugs shall be made from the Trust Fund. Effective date.

Federal Register, publication.

"(d)(1) The Secretary of the Treasury, in consultation with the Board of Trustees of the Trust Fund, shall publish in the Federal Register—

"(A) not later than July 1 of each year (beginning with 1992), information on—

"(i) the outlays made from the Trust Fund in the preceding year, and

"(ii) the balance in the Trust Fund as of the close of the preceding year; and

"(B) during the last 3 days of September of each such year, the prescription drug monthly premiums to be established under section 1839(g) for months in the succeeding year.

Reports.

"(2) The Secretary shall report to Congress, not later than July 1 of each year (beginning with 1992), respecting the distribution of outlays from the Trust Fund in the previous year among major spending categories. The Comptroller General shall report, not later than September 1 of each year, to Congress concerning the completeness and accuracy of the Secretary's report under the previous sentence and of the premiums established under section 1839(g) and under section 59B of the Internal Revenue Code of 1986.

"(e) In this part, with respect to the Trust Fund and the Medicare Catastrophic Coverage Account, the terms 'outlays' and 'receipts' mean, with respect to a quarter or other period, gross outlays and receipts, as such terms are employed in the 'Monthly Treasury Statement of Receipts and Outlays of the United States Government (MTS)', as published by the Department of the Treasury, for months in such quarter or other period.".

(b) TRANSFERS OF CERTAIN PREMIUMS.—

(1) TRANSFER OF FLAT PRESCRIPTION DRUG PREMIUMS TO FEDERAL CATASTROPHIC DRUG INSURANCE TRUST FUND.—Section 1840 (42 U.S.C. 1395s) is amended by adding at the end the following new subsection:

"(i) Notwithstanding the previous provisions of this subsection, premiums collected under this part which are attributable to a prescription drug monthly premium established under section 1839(g) shall, instead of being transferred to (or being deposited to the credit of) the Federal Supplemental Medical Insurance Trust Fund, be transferred to (or deposited to the credit of) the Federal Catastrophic Drug Insurance Trust Fund.".

(2) TRANSFER OF SUPPLEMENTAL CATASTROPHIC COVERAGE PREMIUMS INTO THE SMI TRUST FUND.—Section 1841(a) (42 U.S.C. 1395t(a)) is amended by adding the following: "There are hereby appropriated to the Trust Fund amounts equivalent to 100 percent of the supplemental premiums imposed by section 59B of the Internal Revenue Code of 1986 which are attributable to the catastrophic coverage rate and which are not otherwise appropriated under section 1817A(a)(2) to the Federal Hospital Insurance Catastrophic Coverage Reserve Fund. The amounts appropriated by the preceding sentence shall be transferred from time to time (not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the premiums, specified in the preceding sentence, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the premiums specified in such sentence. At the close of each

year, the transfers under this subsection shall reflect all premiums under section 59B of the Internal Revenue Code of 1986 paid or deposited into the Treasury in the year.".

(c) CONFORMING AMENDMENTS.—

(1)(A) Section 201(g)(1)(A) (42 U.S.C. 401(g)(1)(A)) is amended by striking "and the Federal Supplementary Medical Insurance Trust Fund" and inserting ", Federal Supplementary Medical Insurance Trust Fund, and the Federal Catastrophic Drug Insurance Trust Fund".

(B) Section 201(i)(1) (42 U.S.C. 401(i)(1)) is amended by striking "and the Federal Supplementary Medical Insurance Trust Fund" and inserting ", Federal Hospital Insurance Catastrophic Coverage Reserve Fund, Federal Supplementary Medical Insurance Trust Fund, and the Federal Catastrophic Drug Insurance Trust Fund".

(2) Section 1833(a) (42 U.S.C. 1395l(a)) is amended, in the matter before paragraph (1), by inserting "or, as provided in section 1841A(c), from the Federal Catastrophic Drug Insurance Trust Fund" after "Medical Insurance Trust Fund".

(3) Section 1817(b) (42 U.S.C. 1395i(b)) is amended by inserting after the sixth sentence the following: "Such report shall also identify (and treat separately) those outlays from the Trust Fund which are also outlays from the Medicare Catastrophic Coverage Account created under section 1841B and those outlays for which there are amounts transferred into the Federal Hospital Insurance Catastrophic Coverage Reserve Fund.".

(4) Section 1841(b) (42 U.S.C. 1395t(b)) is amended by inserting after the sixth sentence the following: "Such report shall also identify (and treat separately) those receipts and outlays in the Trust Fund which are also receipts and outlays in the Medicare Catastrophic Coverage Account created under section 1841B.".

SEC. 213. CREATION OF MEDICARE CATASTROPHIC COVERAGE ACCOUNT.

(a) IN GENERAL.—Part B of title XVIII is amended by inserting after section 1841A, as inserted by section 212, the following new section:

"MEDICARE CATASTROPHIC COVERAGE ACCOUNT

"SEC. 1841B. (a) For purposes of carrying out certain provisions of this title, and section 59B of the Internal Revenue Code of 1986, there is hereby created on the books of the Treasury of the United States an account to be known as the 'Medicare Catastrophic Coverage Account' (in this section referred to as the 'Account'), to be maintained by the Secretary of the Treasury in consultation with the Boards of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. No funds shall actually be transferred into or paid out of the Account, but, for other purposes of this part and for purposes of section 59B of the Internal Revenue Code of 1986, amounts credited to the Account shall be considered receipts of the Account and amounts debited to the Account shall be considered outlays from the Account. 42 USC 1395t-2.

"(b)(1) The Account shall be—

"(A) credited for receipts of the Federal Supplementary Medical Insurance Trust Fund attributable to the portion of supplemental premiums under section 59B of the Internal Revenue Code of 1986, and the premiums under section 1839(g), attrib-

utable to the catastrophic coverage premium rate or catastrophic coverage monthly premium,

"(B) credited for receipts of the Federal Hospital Insurance Catastrophic Coverage Reserve Fund, and

"(C) debited for outlays made under this title that are attributable to the amendments made by the Medicare Catastrophic Coverage Act of 1988 (other than outlays relating to covered outpatient drugs and related administrative costs).

"(2) In addition, the Account shall be—

"(A) credited with interest (at the rate used for purposes of the Federal Supplementary Medical Insurance Trust Fund) on any positive average balance maintained in the Account in a calendar quarter, and

"(B) debited with interest (at the rate used for purposes of the Federal Supplementary Medical Insurance Trust Fund) on any negative average balance maintained in the Account in a calendar quarter.

"(3) Credits and debits under this subsection shall be made as of the last date of each month based upon receipts and outlays occurring during the month, as estimated by the Secretary and the Secretary of the Treasury.

"(4) The Account shall also identify (and treat separately) those credits and debits in the Account which are also receipts and outlays in the Federal Supplementary Medical Insurance Trust Fund, those receipts which are also receipts of the Federal Hospital Insurance Catastrophic Coverage Reserve Fund, and those outlays that are also outlays from the Federal Hospital Insurance Trust Fund.

Federal Register, publication.

"(c)(1) The Secretary of the Treasury shall publish in the Federal Register—

"(A) not later than July 1 of each year (beginning with 1990), information on—

"(i) the outlays made from the Account in the preceding year, and

"(ii) the balance in the Account as of the close of the preceding year; and

"(B) during the last 3 days of September of each such year, the catastrophic coverage monthly premiums to be established under section 1839(g) for months in the succeeding year.

Reports.

"(2) The Secretary shall report to Congress, not later than July 1 of each year (beginning with 1990), respecting the distribution of outlays from the Account in the previous year among major spending categories. The Comptroller General shall report, not later than September 1 of each year, to Congress concerning the completeness and accuracy of the Secretary's report under the previous sentence and of the premiums established under section 1839(g) and under section 59B of the Internal Revenue Code of 1986.

Reports.

"(d) The Secretary of the Treasury shall report to Congress in April of each year on the status of the Account created under this section.".

Subtitle C—Miscellaneous Provisions

SEC. 221. VOLUNTARY CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES.

(a) FREE-LOOK PERIOD.—Section 1882 (42 U.S.C. 1395ss) is amended—

(1) in subsection (b)(1)(B), by striking "and (3)" and inserting "through (4)", and

(2) in subsection (c)—

(A) by striking "and" at the end of paragraph (2),

(B) by striking the period at the end of paragraph (3) and inserting "; and", and

(C) by adding at the end thereof the following:

"(4) may, during a period of not less than 30 days after the policy is issued, be returned for a full refund of any premiums paid (without regard to the manner in which the purchase of the policy was solicited).".

(b) REPORTING OF INFORMATION RELATING TO LOSS RATIOS.—Section 1882(b)(1), as amended by subsection (a), is further amended—

(1) in subparagraph (C), by striking "(A) and (B)" and inserting "(A), (B), and (C)",

(2) by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E), respectively, and

(3) by inserting after subparagraph (B) the following new subparagraph:

"(C) provides that—

"(i) information with respect to the actual ratio of benefits provided to premiums collected under such policies will be reported to the State on forms conforming to those developed by the National Association of Insurance Commissioners for such purpose, or

"(ii) such ratios will be monitored under the program in an alternative manner approved by the Secretary;".

(c) CONSUMER INFORMATION.—Section 1882(e) is amended— 42 USC 1395ss.

(1) by inserting "(1)" after "(e)", and

(2) by adding at the end thereof the following:

"(2) The Secretary shall—

"(A) inform all individuals entitled to benefits under this title (and, to the extent feasible, individuals about to become so entitled) of—

"(i) the actions and practices that are subject to sanctions under subsection (d), and

"(ii) the manner in which they may report any such action or practice to an appropriate official of the Department of Health and Human Services (or to an appropriate State official), and

"(B) publish the toll-free telephone number for individuals to report suspected violations of the provisions of such subsection. Law enforcement and crime.

"(3) The Secretary shall provide individuals entitled to benefits under this title (and, to the extent feasible, individuals about to become so entitled) with a listing of the addresses and telephone numbers of State and Federal agencies and offices that provide information and assistance to individuals with respect to the selection of medicare supplemental policies.".

(d) REVISION OF MODEL STANDARDS; TRANSITION.—Section 1882 is further amended—

(1) in the third sentence of subsection (a), by striking "Such certification" and inserting "Subject to subsection (k)(3), such certification";

(2) in subsection (b), by striking "(for so long as" and inserting "(subject to subsection (k)(3), for so long as"; and

(3) by adding at the end thereof the following new subsections:

State and local governments. Effective date.

"(k)(1)(A) If, within the 90-day period beginning on the date of the enactment of this subsection, the National Association of Insurance Commissioners (in this subsection referred to as the 'Association') amends the NAIC Model Regulation adopted on June 6, 1979 (as it relates to medicare supplemental policies), with respect to matters such as minimum benefit standards, loss ratios, disclosure requirements, and replacement requirements and provisions otherwise necessary to reflect the changes in law made by the Medicare Catastrophic Coverage Act of 1988, subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the Model Regulation as amended by the Association in accordance with this paragraph (in this subsection and subsection (l) referred to as the 'amended NAIC Model Regulation').

"(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the amended NAIC Model Regulation or 1 year after the date the Association first adopts such amended Regulation.

Effective date.

"(2)(A) If the Association does not amend the NAIC Model Regulation within the 90-day period specified in paragraph (1)(A), the Secretary shall promulgate, not later than 60 days after the end of such period, Federal model standards (in this subsection and subsection (l) referred to as 'Federal model standards') for medicare supplemental policies to reflect the changes in law made by the Medicare Catastrophic Coverage Act of 1988, and subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to Federal model standards.

"(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the Federal model standards or 1 year after the date the Secretary first promulgates such standards.

"(3) Notwithstanding any other provision of this section (except as provided in subsection (l))—

"(A) no medicare supplemental policy may be certified by the Secretary pursuant to subsection (a),

"(B) no certification made pursuant to subsection (a) shall remain in effect, and

"(C) no State regulatory program shall be found to meet (or to continue to meet) the requirements of subsection (b)(1)(A),

unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set forth in the amended NAIC Model Regulation or the Federal model standards (as the case may be) by the date specified in paragraph (1)(B) or (2)(B) (as the case may be).

State and local governments.

"(l)(1) Until the date specified in paragraph (3), in the case of a qualifying medicare supplemental policy described in paragraph (2) issued—

"(A) before January 1, 1989, the policy is deemed to remain in compliance with this section if the insurer issuing the policy complies with the NAIC Model Transition Regulation (including giving notices to subscribers and filing for premium adjustments with the State as described in section 5.B. of such Regulation) by January 1, 1989; or

"(B) on or after January 1, 1989, the policy is deemed to be in compliance with this section if the insurer issuing the policy complies with the NAIC Model Transition Regulation before the date of the sale of the policy.

"(2) In paragraph (1), the term 'qualifying medicare supplemental policy' means a medicare supplemental policy—

"(A) issued in a State which—

"(i) has not adopted standards equal to or more stringent than the NAIC Model Transition Regulation by January 1, 1989, and

"(ii) has not adopted standards equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards) by January 1, 1989; and

"(B) which has been issued in compliance with this section (as in effect on June 1, 1988).

"(3)(A) The date specified in this paragraph is the earlier of—

"(i) the first date a State adopts, after January 1, 1989, standards equal to or more stringent than the NAIC Model Transition Regulation or equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards), as the case may be, or

"(ii) the later of (I) the date specified in subsection (k)(1)(B) or (k)(2)(B) (as the case may be), or (II) the date specified in subparagraph (B).

"(B) In the case of a State which the Secretary identifies as—

"(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet standards described in subparagraph (A)(i), but

"(ii) having a legislature which is not scheduled to meet in 1989 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1989, and in which legislation described in clause (i) may be considered. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

"(4) In the case of a medicare supplemental policy in effect on January 1, 1989, and offered in a State which, as of such date—

"(A) has adopted standards equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards), but

"(B) does not have in effect standards equal to or more stringent than the NAIC Model Transition Regulation (or otherwise requiring notice substantially the same as the notice required in section 5.B. of such Regulation),

the policy shall not be deemed to meet the standards in subsection (c) unless each individual who is entitled to benefits under this title and is a policyholder under such policy on January 1, 1989, is sent such a notice in any appropriate form by not later than January 31, 1989, that explains—

"(A) the improved benefits under this title contained in the Medicare Catastrophic Coverage Act of 1988, and

"(B) how these improvements affect the benefits contained in the policies and the premium for the policy.

"(5) In this subsection, the term 'NAIC Model Transition Regulation' refers to the standards contained in the 'Model Regulation to Implement Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Medicare Program Revisions' (as adopted by the National Association of Insurance Commissioners in September 1987).

Reports. "(6) The Secretary shall report to the Congress in March 1989 and in July 1990 on actions States have taken in adopting standards equal to or more stringent than the NAIC Model Transition Regulation or the amended NAIC Model Regulation (or Federal model standards).".

42 USC 1395ss. (e) REQUIRED SUBMISSION OF ADVERTISING.—Section 1882(b) is further amended by adding at the end the following new paragraph:

State and local governments. "(3) Notwithstanding paragraph (1), a medicare supplemental policy offered in a State shall not be deemed to meet the standards and requirements set forth in subsection (c), with respect to an advertisement (whether through written, radio, or television medium) used (or, at a State's option, to be used) for the policy in the State, unless the entity issuing the policy provides a copy of each advertisement to the Commissioner of Insurance (or comparable officer identified by the Secretary) of that State for review or approval to the extent it may be required under State law.".

(f) APPOINTMENT OF SUPPLEMENTAL HEALTH INSURANCE PANEL MEMBERS.—Section 1882(b)(2)(A) is amended by striking "appointed by the President" and inserting "appointed by the Secretary".

42 USC 1395ss note. (g) EFFECTIVE DATES.—

(1) Except as provided in paragraphs (2) and (3), the amendments made by this section shall take effect on the date of the enactment of this Act.

(2) The amendments made by subsections (a) and (b) shall become effective on the date specified in subsection (k)(1)(B) or (k)(2)(B) of section 1882 of the Social Security Act (as added by subsection (c) of this section).

(3) The amendment made by subsection (f) shall apply to medicare supplemental policies as of January 1, 1989, with respect to advertising used on or after such date.

(4) The Secretary of Health and Human Services shall provide for the reappointment of members to the Supplemental Health Insurance Panel (under section 1882(b)(2) of the Social Security Act) by not later than 90 days after the date of the enactment of this Act.

42 USC 1395mm note. **SEC. 222. ADJUSTMENT OF CONTRACTS WITH PREPAID HEALTH PLANS.**

The Secretary of Health and Human Services shall—

(1) modify contracts under sections 1833(a)(1)(A) and 1876 of the Social Security Act, for portions of contract years occurring after December 31, 1988, to take into account the amendments made by this Act; and

(2) require such organizations to make appropriate adjustments (including adjustments in premiums and benefits) in the terms of their agreements with medicare beneficiaries to take into account such amendments.

The Secretary shall also provide for appropriate modifications of contracts with health maintenance organizations under section 1876(i)(2)(A) of the Social Security Act (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967, or under section 222(a) of the Social Security Amendments of

1972, for portions of contract years occurring after December 31, 1988, so as to apply to such organizations and contracts the requirements imposed by the amendments made by this Act upon an organization with a risk-sharing contract under section 1876 of the Social Security Act.

SEC. 223. MAILING OF NOTICE OF MEDICARE BENEFITS AND INFORMATION DESCRIBING PARTICIPATING PHYSICIAN PROGRAM.

(a) DISTRIBUTION OF NOTICES.—Title XVIII is amended by inserting after section 1803 the following new section:

"NOTICE OF MEDICARE BENEFITS

"SEC. 1804. The Secretary shall prepare (in consultation with groups representing the elderly and with health insurers) and provide for distribution of a notice containing— 42 USC 1395b-2.

"(1) a clear, simple explanation of the benefits available under this title and the major categories of health care for which benefits are not available under this title,

"(2) the limitations on payment (including deductibles and coinsurance amounts) that are imposed under this title, and

"(3) a description of the limited benefits for long-term care services available under this title and generally available under State plans approved under title XIX.

Such notice shall be mailed annually to individuals entitled to benefits under part A or part B of this title and when an individual applies for benefits under part A or enrolls under part B.".

(b) DISTRIBUTION OF INFORMATION DESCRIBING PARTICIPATING PHYSICIAN PROGRAM.—Section 1842(h)(5) (42 U.S.C. 1395u(h)(5)) is amended—

(1) by inserting "through an annual mailing" after "under this part",

(2) by striking the last sentence,

(3) by inserting "(A)" after "(5)", and

(4) by adding at the end the following new subparagraph:

"(B) The annual notice provided under subparagraph (A) shall include—

"(i) a description of the participation program,

"(ii) an explanation of the advantages to beneficiaries of obtaining covered services through a participating physician or supplier,

"(iii) an explanation of the assistance offered by carriers in obtaining the names of participating physicians and suppliers, and

"(iv) the toll-free telephone number under paragraph (2)(A) for inquiries concerning the program and for requests for free copies of appropriate directories.".

(c) REVISION OF EXPLANATION OF MEDICARE BENEFITS.—Section 1842(h)(7) (42 U.S.C. 1395u(h)(7)) is amended—

(1) in subparagraph (A)—

(A) by inserting "prominent" before "reminder", and

(B) by striking "), and" and inserting "and a clear statement of any amounts charged for the particular items or services on the claim involved above the amount recognized under this part),";

(2) in subparagraph (B), by striking the period at the end and inserting ", and"; and

(3) by adding at the end the following new subparagraph:
"(C) shall include (i) an offer of assistance to such an individual in obtaining the names of participating physicians of appropriate specialty and (ii) an offer to provide a free copy of the appropriate participating physician directory.".

(d) EFFECTIVE DATES.—

42 USC 1395b-2 note.

(1) The Secretary of Health and Human Services shall first distribute the notice required by the amendment made by subsection (a) not later than January 31, 1989.

42 USC 1395u note.

(2) The amendments made by subsection (b) shall apply to annual notices beginning with 1989.

42 USC 1395u note.

(3) The amendments made by subsection (c) shall first apply to explanations of benefits provided for items and services furnished on or after January 1, 1989.

SEC. 224. CHANGES IN CIVIL MONEY PENALTIES FOR CERTAIN PRACTICES OF HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.

Section 1876(i)(6)(B)(i) (42 U.S.C. 1395mm(i)(6)(B)(i)) is amended by adding at the end the following: "plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iv), $15,000 for each individual not enrolled as a result of the practice involved,".

TITLE III—PROVISIONS RELATING TO THE MEDICAID PROGRAM

SEC. 301. REQUIRING MEDICAID BUY-IN OF PREMIUMS AND COST-SHARING FOR INDIGENT MEDICARE BENEFICIARIES.

(a) REQUIREMENT.—

(1) Section 1902(a)(10)(E) (42 U.S.C. 1396a(a)(10)(E)) is amended by striking "at the option of a State, but".

(2) Section 1905(p)(1)(B) (42 U.S.C. 1396d(p)(1)(B)) is amended by striking "and the election of the State".

(b) PHASING-IN REQUIRED INCOME STANDARD TO 100 PERCENT OF POVERTY LEVEL.—Section 1905(p)(2)(A) (42 U.S.C. 1396d(p)(2)(A)) is amended—

(1) by striking "may not exceed a percentage (not more than 100 percent)" and inserting "shall be at least the percent provided under clause (ii) (but not more than 100 percent)",

(2) by inserting "(i)" after "(2)(A)", and

(3) by adding at the end the following new clause:

"(ii) Except as provided in clause (iii), the percent provided under this clause, with respect to eligibility for medical assistance on or after—

"(I) January 1, 1989, is 85 percent,

"(II) January 1, 1990, is 90 percent,

"(III) January 1, 1991, is 95 percent, and

"(IV) January 1, 1992, is 100 percent.

"(iii) In the case of a State which has elected treatment under section 1902(f) and which, as of January 1, 1987, used an income standard for individuals age 65 or older which was more restrictive

than the income standard established under the supplemental security income program under title XVI, the percent provided under clause (ii), with respect to eligibility for medical assistance on or after—

"(I) January 1, 1989, is 80 percent,

"(II) January 1, 1990, is 85 percent,

"(III) January 1, 1991, is 90 percent,

"(IV) January 1, 1992, is 95 percent, and

"(V) January 1, 1993, is 100 percent.".

(c) RESOURCE STANDARD.—Section 1905(p) (42 U.S.C. 1396d(p)) is amended—

(1) in paragraph (1)(C), by striking "(2)(A)" and inserting "(2)";

(2) in paragraph (1)(D), by striking "(except as provided in paragraph (2)(B))" and inserting "twice"; and

(3) in paragraph (2)—

(A) in subparagraph (A), by striking "(2)(A)" and inserting "(2)", and

(B) by striking subparagraph (B).

(d) MEDICARE COVERAGE.—Section 1905(p) (42 U.S.C. 1396d(p)) is amended—

(1) in paragraph (3)(A), by striking "under part B and (if applicable) under section 1818" and inserting "under title XVIII (including under part B and, if applicable, under section 1818)";

(2) by amending subparagraphs (B) and (C) of paragraph (3) to read as follows:

"(B) Coinsurance under title XVIII (including coinsurance described in section 1813).

"(C) Subject to paragraph (4), deductibles established under title XVIII (including those described in section 1813, 1833(b), and section 1834(c)(1)).";

(3) by adding at the end the following new paragraph:

"(4) In a State which provides medical assistance for prescribed drugs under section 1905(a)(12), instead of providing to qualified medicare beneficiaries, under paragraph (3)(C), medicare cost-sharing with respect to the annual deductible for covered outpatient drugs under section 1834(c)(1), the State may provide to such beneficiaries, before charges for covered outpatient drugs for a year reach such deductible amount, benefits for prescribed drugs in the same amount, duration, and scope as the benefits made available under the State plan for individuals described in section 1902(a)(10)(A)(i).". State and local governments. Prescription drugs.

(e) CONFORMING AMENDMENTS.—

(1) Section 1843 (42 U.S.C. 1395v) is amended by inserting "or after 1988" in subsections (a), (g)(1), and (h)(1) after "during 1981".

(2) Section 1902 (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(10)(A)(ii)(X), by striking "subject to subsection (m)(3),",

(B) in subsection (a)(10)(E), by striking "subject to subsection (m)(3),";

(C) in subsection (a)(17), by striking "(m)(4), and (m)(5)" and inserting "(m)(3), and (m)(4)", and

(D) in subsection (m), by striking paragraph (3) and by redesignating paragraphs (4) and (5) as paragraphs (3) and (4), respectively.

Effective dates. 42 USC 1395v note.

(3) The amendment made by paragraph (1) shall take effect on January 1, 1989, and the amendments made by paragraph (2) shall take effect on July 1, 1989.

Effective date.

(f) TECHNICAL AMENDMENT.—Effective as though included in the enactment of the Omnibus Budget Reconciliation Act of 1986, paragraph (2) of section 9403(g) of such Act is amended to read as follows:

"(2) PAYMENT OF MEDICARE COST-SHARING.—Section 1903(a)(1) (42 U.S.C. 1396b(a)(1)) is amended by inserting 'including expenditures for medicare cost-sharing and' before 'including expenditures'.".

42 USC 1396a note.

(g) TREATMENT OF CERTAIN STATES.—

(1) STATES OPERATING UNDER DEMONSTRATION PROJECTS.—In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115(a) of the Social Security Act, the Secretary of Health and Human Services shall require the State to meet the requirement of section 1902(a)(10)(E) of the Social Security Act in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under title XIX of such Act.

(2) COMMONWEALTHS AND TERRITORIES.—Section 1905(p) (42 U.S.C. 1396d(p)), as amended by subsection (d)(3), is further amended by adding at the end the following new paragraph:

"(5) Notwithstanding any other provision of this title, in the case of a State (other than the 50 States and the District of Columbia)—

"(A) the requirement stated in section 1902(a)(10)(E) shall be optional, and

"(B) for purposes of paragraph (2)(A), the State may substitute for the percent provided under clause (ii) of such paragraph any percent.".

42 USC 1396a note.

(h) EFFECTIVE DATE.—(1) The amendments made by this section apply (except as provided in subsections (e) and (f) and under paragraph (2)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after January 1, 1989, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, with respect to medical assistance for—

(A) monthly premiums under title XVIII of such Act for months beginning with January 1989, and

(B) items and services furnished on and after January 1, 1989.

State and local governments.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

State and local governments.

SEC. 302. COVERAGE AND PAYMENT FOR PREGNANT WOMEN AND INFANTS WITH INCOMES BELOW POVERTY LINE.

(a) PREGNANT WOMEN AND INFANTS UNDER AGE 1.—

(1) REQUIRING COVERAGE.—Section 1902(a)(10) (42 U.S.C. 1396a(a)(10)) is amended—

(A) in subparagraph (A)(i), by striking "or" at the end of subclause (II), by striking the semicolon in subclause (III) and inserting ", or", and by adding at the end the following new subclause:

"(IV) who are described in subparagraph (A) or (B) of subsection (l)(1) and whose family income does not exceed the minimum income level the State is required to establish under subsection (l)(2)(A) for such a family;";

(B) by amending subclause (IX) of subparagraph (A)(ii) to read as follows:

"(IX) who are described in subsection (l)(1) and are not described in clause (i)(IV);"; and

(C) in clause (VII) in the matter after and below subparagraph (E), by inserting "(A)(i)(IV) or" before "(A)(ii)(IX)".

(2) DESCRIPTION OF INDIVIDUALS REQUIRED TO BE COVERED.—Section 1902(l) (42 U.S.C. 1396a(l)) is amended—

(A) in paragraph (1)(C)—

(i) by inserting "at the option of the State," after "(C)", and

(ii) by striking "and" after "1983,"; and

(B) in paragraph (2)(A)—

(i) by striking "not more than 185 percent)" and inserting "(not less than the percentage provided under clause (ii) and not more than 185 percent)";

(ii) by inserting "(i)" after "(2)(A)"; and

(iii) by adding at the end the following new clause:

"(ii) Subject to clause (iii), the percentage provided under this clause, with respect to eligibility for medical assistance on or after—

"(I) July 1, 1989, is 75 percent, and

"(II) July 1, 1990, is 100 percent.

"(iii) In the case of a State which, as of the date of the enactment of this clause, has elected to provide, and provides, medical assistance to individuals described in this subsection or has enacted legislation authorizing, or appropriating funds, to provide such assistance to such individuals before July 1, 1989, the percentage provided under clause (ii) shall not be less than—

"(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of the date of the enactment of this clause, or

"(II) if no such percentage is specified as of the date of the enactment of this clause, the percentage established under the State's authorizing legislation or provided for under the State's appropriations;

but in no case shall this clause require the percentage provided under clause (ii) to exceed 100 percent.".

(b) COVERAGE OF MEDICALLY NECESSARY SERVICES FOR INFANTS AND ASSURING ADEQUATE PAYMENT FOR INPATIENT HOSPITAL SERVICES FOR INFANTS IN DISPROPORTIONATE SHARE HOSPITALS.—

(1) COVERAGE OF MEDICALLY NECESSARY SERVICES FOR INFANTS.—Section 1902(a)(10) (42 U.S.C. 1396a(a)(10)) is amended, in the matter after and below subparagraph (E)—

(A) by striking "and" before "(IX)", and

(B) by inserting before the semicolon at the end the following: ", and (X) if the plan provides for any fixed

durational limit on medical assistance for inpatient hospital services (whether or not such a limit varies by medical condition or diagnosis), the plan must establish exceptions to such a limit for medically necessary inpatient hospital services furnished with respect to individuals under one year of age in a hospital defined under the State plan, pursuant to section 1923(a)(1)(A), as a disproportionate share hospital and subparagraph (B) (relating to comparability) shall not be construed as requiring such an exception for other individuals, services, or hospitals".

(2) ASSURING ADEQUATE PAYMENT FOR INPATIENT HOSPITAL SERVICES FOR INFANTS IN DISPROPORTIONATE SHARE HOSPITALS.—Section 1923(a)(2), as redesignated pursuant to the amendment made by section 411(k)(6)(B) of this Act, is amended by adding at the end the following new subparagraph:

42 USC 1396r-4.

"(C) If a State plan under this title provides for payments for inpatient hospital services on a prospective basis (whether per diem, per case, or otherwise), in order for the plan to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, a State plan amendment that provides, in the case of hospitals defined by the State as disproportionate share hospitals under paragraph (1)(A), for an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age.".

(c) CERTAIN STATE PLAN REQUIREMENTS.—

(1) IN GENERAL.—Subsection (c) of section 1902 (42 U.S.C. 1396a) is amended to read as follows:

"(c) Notwithstanding subsection (b), the Secretary shall not approve any State plan for medical assistance if—

"(1) the State has in effect, under its plan established under part A of title IV, payment levels that are less than the payment levels in effect under such plan on May 1, 1988; or

"(2) the State requires individuals described in subsection (l)(1) to apply for benefits under such part as a condition of applying for, or receiving, medical assistance under this title.".

(2) ELIMINATING DUPLICATE REQUIREMENT.—Section 1902(l) (42 U.S.C. 1396a(l)) is amended by striking paragraph (4).

(3) MAINTENANCE OF EFFORT TO RECEIVE MEDICAL ASSISTANCE FOR OPTIONAL COVERAGE OF PREGNANT WOMEN AND CHILDREN.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended—

(A) by striking the period at the end of paragraph (8) and inserting "; or", and

(B) by inserting after paragraph (8) the following new paragraph:

"(9) with respect to any amount of medical assistance for pregnant women and children described in section 1902(a)(10)(A)(ii)(IX), if the State has in effect, under its plan established under part A of title IV, payment levels that are less than the payment levels in effect under such plan on July 1, 1987.".

(d) TREATMENT OF CERTAIN STATES AND TERRITORIES.—Section 1902(l) (42 U.S.C. 1396a(l)) is amended by adding at the end the following new paragraph:

"(4)(A) In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the

Secretary shall require the State to provide medical assistance for pregnant women and infants under age 1 described in subsection (a)(10)(A)(i)(IV) in the same manner as the State would be required to provide such assistance for such individuals if the State had in effect a plan approved under this title.

"(B) In the case of a State which is not one of the 50 States or the District of Columbia, the State need not meet the requirement of subsection (a)(10)(A)(i)(IV) and, for purposes of paragraph (2)(A), the State may substitute for the percentage provided under clause (ii) of such paragraph any percentage.".

(e) CONFORMING AMENDMENTS.—

(1) Section 1902(e)(6) (42 U.S.C. 1396a(e)(6)) is amended to read as follows:

"(6) At the option of a State, in the case of a pregnant woman described in subsection (a)(10) who, because of a change in income of the family of which she is a member, would not otherwise continue to be described in such subsection, the State plan may nonetheless treat the woman as being an individual described in subsection (a)(10)(A)(i)(IV) and subsection (l)(1)(A) without regard to such change of income through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends.".

(2) Section 1902(e)(7) (42 U.S.C. 1396a(e)(7)) is amended—

(A) by striking "If a State plan provides medical assistance for individuals under subsection (a)(10)(A)(ii)(IX), in" and inserting "In",

(B) by inserting "or paragraph (2) of section 1905(n)" after "subsection (l)(1)" the first place it appears, and

(C) by striking "subsection (a)(10)(A)(ii)(IX) and subsection (l)(1)" and inserting "such respective provision".

(3) Section 1902(l) (42 U.S.C. 1396a(l)) is amended—

(A) in the matter after and below subparagraph (C) of paragraph (1), by inserting "any of subclauses (I) through (III) of" after "who are not described in", and

(B) in paragraph (3), in the matter before subparagraph (A), by inserting "(a)(10)(A)(i)(IV) or" before "(a)(10)(A)(ii)(IX)".

(4) Section 1903(f)(4) (42 U.S.C. 1396b(f)(4)) is amended, in the matter before subparagraph (A), by inserting "1902(a)(10)(A)(i)(IV)," before "1902(a)(10)(A)(ii)(IX)".

(f) EFFECTIVE DATE.— 42 USC 1396a note.

(1) IN GENERAL.—The amendments made by this section apply (except as provided in this subsection) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1989, with respect to eligibility for medical assistance on or after such date, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) PAYMENT ADJUSTMENT.—The amendments made by subsection (b)(2) shall take effect on the date of the enactment of this Act.

(3) DELAY FOR STATE LEGISLATION.—In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section (other than subsection (b)(2)), the State plan shall not be regarded as failing

to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a regular legislative session of 2 years, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 303. PROTECTION OF INCOME AND RESOURCES OF COUPLE FOR MAINTENANCE OF COMMUNITY SPOUSE.

(a) IN GENERAL.—

(1) Title XIX, as amended by the amendment made by section 411(k)(6)(B) of this Act, is amended—

42 USC 1396s.

(A) by redesignating section 1924 as section 1925, and

(B) by inserting after section 1923 the following new section:

"TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES

42 USC 1396r-5.

"SEC. 1924. (a) SPECIAL TREATMENT FOR INSTITUTIONALIZED SPOUSES.—

"(1) SUPERSEDES OTHER PROVISIONS.—In determining the eligibility for medical assistance of an institutionalized spouse (as defined in subsection (h)(1)), the provisions of this section supersede any other provision of this title (including sections 1902(a)(17) and 1902(f)) which is inconsistent with them.

"(2) NO COMPARABLE TREATMENT REQUIRED.—Any different treatment provided under this section for institutionalized spouses shall not, by reason of paragraph (10) or (17) of section 1902(a), require such treatment for other individuals.

"(3) DOES NOT AFFECT CERTAIN DETERMINATIONS.—Except as this section specifically provides, this section does not apply to—

"(A) the determination of what constitutes income or resources, or

"(B) the methodology and standards for determining and evaluating income and resources.

"(4) APPLICATION IN CERTAIN STATES AND TERRITORIES.—

"(A) APPLICATION IN STATES OPERATING UNDER DEMONSTRATION PROJECTS.—In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.

"(B) NO APPLICATION IN COMMONWEALTHS AND TERRITORIES.—This section shall only apply to a State that is one of the 50 States or the District of Columbia.

"(b) RULES FOR TREATMENT OF INCOME.—

"(1) SEPARATE TREATMENT OF INCOME.—During any month in which an institutionalized spouse is in the institution, except as provided in paragraph (2), no income of the community spouse shall be deemed available to the institutionalized spouse.

"(2) ATTRIBUTION OF INCOME.—In determining the income of an institutionalized spouse or community spouse, after the

institutionalized spouse has been determined to be eligible for medical assistance, except as otherwise provided in this section and regardless of any State laws relating to community property or the division of marital property, the following rules apply:

"(A) NON-TRUST PROPERTY.—Subject to subparagraphs (C) and (D), in the case of income not from a trust, unless the instrument providing the income otherwise specifically provides—

"(i) if payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

"(ii) if payment of income is made in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

"(iii) if payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

"(B) TRUST PROPERTY.—In the case of a trust—

"(i) except as provided in clause (ii), income shall be attributed in accordance with the provisions of this title (including sections 1902(a)(17) and 1902(k)), and

"(ii) income shall be considered available to each spouse as provided in the trust, or, in the absence of a specific provision in the trust—

"(I) if payment of income is made solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

"(II) if payment of income is made to both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

"(III) if payment of income is made to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

"(C) PROPERTY WITH NO INSTRUMENT.—In the case of income not from a trust in which there is no instrument establishing ownership, subject to subparagraph (D), one-half of the income shall be considered to be available to the institutionalized spouse and one-half to the community spouse.

"(D) REBUTTING OWNERSHIP.—The rules of subparagraphs (A) and (C) are superseded to the extent that an institutionalized spouse can establish, by a preponderance of the

evidence, that the ownership interests in income are other than as provided under such subparagraphs.

"(c) RULES FOR TREATMENT OF RESOURCES.—

"(1) COMPUTATION OF SPOUSAL SHARE AT TIME OF INSTITUTIONALIZATION.—

"(A) TOTAL JOINT RESOURCES.—There shall be computed (as of the beginning of a continuous period of institutionalization of the institutionalized spouse)—

"(i) the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest, and

"(ii) a spousal share which is equal to ½ of such total value.

State and local governments. Records.

"(B) ASSESSMENT.—At the request of an institutionalized spouse or community spouse, at the beginning of a continuous period of institutionalization of the institutionalized spouse and upon the receipt of relevant documentation of resources, the State shall promptly assess and document the total value described in subparagraph (A)(i) and shall provide a copy of such assessment and documentation to each spouse and shall retain a copy of the assessment for use under this section. If the request is not part of an application for medical assistance under this title, the State may, at its option as a condition of providing the assessment, require payment of a fee not exceeding the reasonable expenses of providing and documenting the assessment. At the time of providing the copy of the assessment, the State shall include a notice indicating that the spouse has right to a fair hearing under subsection (e)(2)(E) with respect to the determination of the community spouse resource allowance, to provide for an allowance adequate to raise the spouse's income to the minimum monthly maintenance needs allowance.

"(2) ATTRIBUTION OF RESOURCES AT TIME OF INITIAL ELIGIBILITY DETERMINATION.—In determining the resources of an institutionalized spouse at the time of application for benefits under this title, regardless of any State laws relating to community property or the division of marital property—

"(A) except as provided in subparagraph (B), all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse, and

"(B) resources shall not be considered to be available to an institutionalized spouse, to the extent that the amount of such resources does not exceed the amount computed under subsection (f)(2)(A) (as of the time of application for benefits).

"(3) ASSIGNMENT OF SUPPORT RIGHTS.—The institutionalized spouse shall not be ineligible by reason of resources determined under paragraph (2) to be available for the cost of care where—

"(A) the institutionalized spouse has assigned to the State any rights to support from the community spouse;

"(B) the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but the State has the right to bring a support proceeding against a community spouse without such assignment; or

"(C) the State determines that denial of eligibility would work an undue hardship.

"(4) SEPARATE TREATMENT OF RESOURCES AFTER ELIGIBILITY FOR BENEFITS ESTABLISHED.—During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be eligible for benefits under this title, no resources of the community spouse shall be deemed available to the institutionalized spouse.

"(5) RESOURCES DEFINED.—In this section, the term 'resources' does not include—

"(A) resources excluded under subsection (a) or (d) of section 1613, and

"(B) resources that would be excluded under section 1613(a)(2)(A) but for the limitation on total value described in such section.

"(d) PROTECTING INCOME FOR COMMUNITY SPOUSE.—

"(1) ALLOWANCES TO BE OFFSET FROM INCOME OF INSTITUTIONALIZED SPOUSE.—After an institutionalized spouse is determined to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

"(A) A personal needs allowance (described in section 1902(q)(1)), in an amount not less than the amount specified in section 1902(q)(2).

"(B) A community spouse monthly income allowance (as defined in paragraph (2)), but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse.

"(C) A family allowance, for each family member, equal to at least ⅓ of the amount by which the amount described in paragraph (3)(A)(i) exceeds the amount of the monthly income of that family member.

"(D) Amounts for incurred expenses for medical or remedial care for the institutionalized spouse (as provided under section 1902(r)).

In subparagraph (C), the term 'family member' only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

"(2) COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE DEFINED.—In this section (except as provided in paragraph (5)), the 'community spouse monthly income allowance' for a community spouse is an amount by which—

"(A) except as provided in subsection (e), the minimum monthly maintenance needs allowance (established under and in accordance with paragraph (3)) for the spouse, exceeds

"(B) the amount of monthly income otherwise available to the community spouse (determined without regard to such an allowance).

"(3) ESTABLISHMENT OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—

"(A) IN GENERAL.—Each State shall establish a minimum monthly maintenance needs allowance for each community

State and local governments.

spouse which, subject to subparagraph (C), is equal to or exceeds—

"(i) the applicable percent (described in subparagraph (B)) of 1/12 of the nonfarm income official poverty line (defined by the Office of Management and Budget and revised annually in accordance with sections 652 and 673(2) of the Omnibus Budget Reconciliation Act of 1981) for a family unit of 2 members; plus

"(ii) an excess shelter allowance (as defined in paragraph (4)).

A revision of the official poverty line referred to in clause (i) shall apply to medical assistance furnished during and after the second calendar quarter that begins after the date of publication of the revision.

"(B) APPLICABLE PERCENT.—For purposes of subparagraph (A)(i), the 'applicable percent' described in this paragraph, effective as of—

"(i) September 30, 1989, is 122 percent,

"(ii) July 1, 1991, is 133 percent, and

"(iii) July 1, 1992, is 150 percent.

"(C) CAP ON MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—The minimum monthly maintenance needs allowance established under subparagraph (A) may not exceed $1,500 (subject to adjustment under subsections (e) and (g)).

"(4) EXCESS SHELTER ALLOWANCE DEFINED.—In paragraph (3)(A)(ii), the term 'excess shelter allowance' means, for a community spouse, the amount by which the sum of—

"(A) the spouse's expenses for rent or mortgage payment (including principal and interest), taxes and insurance and, in the case of a condominium or cooperative, required maintenance charge, for the community spouse's principal residence, and

"(B) the standard utility allowance (used by the State under section 5(e) of the Food Stamp Act of 1977) or, if the State does not use such an allowance, the spouse's actual utility expenses,

exceeds 30 percent of the amount described in paragraph (3)(A)(i), except that, in the case of a condominium or cooperative, for which a maintenance charge is included under subparagraph (A), any allowance under subparagraph (C) shall be reduced to the extent the maintenance charge includes utility expenses.

"(5) COURT ORDERED SUPPORT.—If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly income so ordered.

"(e) NOTICE AND FAIR HEARING.—

State and local governments.

"(1) NOTICE.—Upon—

"(A) a determination of eligibility for medical assistance of an institutionalized spouse, or

"(B) a request by either the institutionalized spouse, or the community spouse, or a representative acting on behalf of either spouse,

each State shall notify both spouses (in the case described in subparagraph (A)) or the spouse making the request (in the case

described in subparagraph (B)) of the amount of the community spouse monthly income allowance (described in subsection (d)(1)(B)), of the amount of any family allowances (described in subsection (d)(1)(C)), of the method for computing the amount of the community spouse resources allowance permitted under subsection (f), and of the spouse's right to a fair hearing under this subsection respecting ownership or availability of income or resources, and the determination of the community spouse monthly income or resource allowance.

"(2) FAIR HEARING.—

"(A) IN GENERAL.—If either the institutionalized spouse or the community spouse is dissatisfied with a determination of—

"(i) the community spouse monthly income allowance;

"(ii) the amount of monthly income otherwise available to the community spouse (as applied under subsection (d)(2)(B));

"(iii) the computation of the spousal share of resources under subsection (c)(1);

"(iv) the attribution of resources under subsection (c)(2); or

"(v) the determination of the community spouse resource allowance (as defined in subsection (f)(2));

such spouse is entitled to a fair hearing described in section 1902(a)(3) with respect to such determination. Any such hearing respecting the determination of the community spouse resource allowance shall be held within 30 days of the date of the request for the hearing.

"(B) REVISION OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—If either such spouse establishes that the community spouse needs income, above the level otherwise provided by the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, there shall be substituted, for the minimum monthly maintenance needs allowance in subsection (d)(2)(A), an amount adequate to provide such additional income as is necessary.

"(C) REVISION OF COMMUNITY SPOUSE RESOURCE ALLOWANCE.—If either such spouse establishes that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under subsection (f)(2), an amount adequate to provide such a minimum monthly maintenance needs allowance.

"(f) PERMITTING TRANSFER OF RESOURCES TO COMMUNITY SPOUSE.—

"(1) IN GENERAL.—An institutionalized spouse may, without regard to section 1917, transfer to the community spouse (or to another for the sole benefit of the community spouse) an amount equal to the community spouse resource allowance (as defined in paragraph (2)), but only to the extent the resources of the institutionalized spouse are transferred to (or for the sole benefit of) the community spouse. The transfer under the preceding sentence shall be made as soon as pacticable after the date of the initial determination of eligibility, taking into ac-

count such time as may be necessary to obtain a court order under paragraph (3).

"(2) COMMUNITY SPOUSE RESOURCE ALLOWANCE DEFINED.—In paragraph (1), the 'community spouse resource allowance' for a community spouse is an amount (if any) by which—

"(A) the greatest of—

"(i) $12,000 (subject to adjustment under subsection (g)), or, if greater (but not to exceed the amount specified in clause (ii)(II)) an amount specified under the State plan,

"(ii) the lesser of (I) the spousal share computed under subsection (c)(1), or (II) $60,000 (subject to adjustment under subsection (g)),

"(iii) the amount established under subsection (e)(2); or

"(iv) the amount transferred under a court order under paragraph (3);

exceeds

"(B) the amount of the resources otherwise available to the community spouse (determined without regard to such an allowance).

"(3) TRANSFERS UNDER COURT ORDERS.—If a court has entered an order against an institutionalized spouse for the support of the community spouse, section 1917 shall not apply to amounts of resources transferred pursuant to such order for the support of the spouse of a family member (as defined in subsection (d)(1)).

"(g) INDEXING DOLLAR AMOUNTS.—For services furnished during a calendar year after 1989, the dollar amounts specified in subsections (d)(3)(C), (f)(2)(A)(i), and (f)(2)(A)(ii)(II) shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between September 1988 and the September before the calendar year involved.

"(h) DEFINITIONS.—In this section:

"(1) The term 'institutionalized spouse' means an individual who—

"(A) is in a medical institution or nursing facility or who (at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI), and

"(B) is married to a spouse who is not in a medical institution or nursing facility;

but does not include any such individual who is not likely to meet the requirements of subparagraph (A) for at least 30 consecutive days.

"(2) The term 'community spouse' means the spouse of an institutionalized spouse.".

(2) Section 1919(c)(1)(B)(i) (42 U.S.C. 1396r(c)(1)(B)(i)) is amended by inserting "and of the requirements and procedures for establishing eligibility for medical assistance under this title, including the right to request an assessment under section 1924(c)(1)(B)" before the semicolon.

(b) TAKING INTO ACCOUNT CERTAIN TRANSFERS OF ASSETS.—Subsection (c) of section 1917 (42 U.S.C. 1396p) is amended to read as follows:

State and local governments.

"(c)(1) In order to meet the requirements of this subsection (for purposes of section 1902(a)(51)(B)), the State plan must provide for a

period of ineligibility in the case of an institutionalized individual (as defined in paragraph (3)) who, at any time during the 30-month period immediately before the individual's application for medical assistance under the State plan, disposed of resources for less than fair market value. The period of ineligibility shall begin with the month in which such resources were transferred and the number of months in such period shall be equal to the lesser of—

"(A) 30 months, or

"(B)(i) the total uncompensated value of the resources so transferred, divided by (ii) the average cost, to a private patient at the time of the application, of nursing facility services in the State or, at State option, in the community in which the individual is institutionalized.

"(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

"(A) the resources transferred were a home and title to the home was transferred to— Real property.

"(i) the spouse of such individual;

"(ii) a child of such individual who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614; Children and youth. Blind persons. Handicapped persons.

"(iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution or nursing facility; or

"(iv) a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual's home for a period of at least two years immediately before the date of such individual's admission to the medical institution or nursing facility, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

"(B) the resources were transferred to (or to another for the sole benefit of) the community spouse, as defined in section 1924(h)(2), or the individual's child who is blind or permanently and totally disabled; Children and youth. Blind persons. Handicapped persons.

"(C) a satisfactory showing is made to the State (in accordance with any regulations promulgated by the Secretary) that (i) the individual intended to dispose of the resources either at fair market value, or for other valuable consideration, or (ii) the resources were transferred exclusively for a purpose other than to qualify for medical assistance; or

"(D) the State determines that denial of eligibility would work an undue hardship.

"(3) In this subsection, the term 'institutionalized individual' means an individual who is an inpatient in a medical institution or nursing facility.

"(4) A State (including a State which has elected treatment under section 1902(f)) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with this subsection.".

(c) NEW SSI POLICY REGARDING DISPOSAL OF RESOURCES FOR LESS THAN FAIR MARKET VALUE.—

(1) ELIMINATION OF SSI PENALTY; NOTIFICATION OF MEDICAID POLICY LIMITING ELIGIBILITY OF INSTITUTIONALIZED INDIVIDUALS FOR BENEFITS BASED ON SUCH DISPOSAL OF RESOURCES.—Subsection (c) of section 1613 (42 U.S.C. 1382b) is amended to read as follows:

"Notification of Medicaid Policy Restricting Eligibility of Institutionalized Individuals for Benefits Based on Disposal of Resources for Less Than Fair Market Value

"(c)(1) At the time an individual (and the individual's eligible spouse, if any) applies for benefits under this title, and at the time the eligibility of an individual (and such spouse, if any) for such benefits is redetermined, the Secretary shall—

"(A) inform such individual of the provisions of section 1917(c) providing for a period of ineligibility for benefits under title XIX for individuals who make certain dispositions of resources for less than fair market value, and inform such individual that information obtained pursuant to subparagraph (B) will be made available to the State agency administering a State plan under title XIX (as provided in paragraph (2)); and

"(B) obtain from such individual information which may be used by the State agency in determining whether or not a period of ineligibility for such benefits would be required by reason of section 1917(c) if such individual (or such spouse, if any) enters a medical institution or nursing facility.

State and local governments.

"(2) The Secretary shall make the information obtained under paragraph (1)(B) available, on request, to any State agency administering a State plan approved under title XIX.".

(2) CONFORMING AMENDMENT.—Subparagraph (B) of section 1611(e)(1) (42 U.S.C. 1382(e)(1)) is amended by adding after and below clause (iii) the following new sentence:

"For purposes of this subsection, a hospital, extended care facility, nursing home, or intermediate care facility which is a 'medical institution or nursing facility' within the meaning of section 1917(c) shall be considered to be receiving payments with respect to an individual under a State plan approved under title XIX during any period of ineligibility of such individual provided for under the State plan pursuant to section 1917(c).".

(d) DISREGARDING PAYMENTS FOR CERTAIN MEDICAL EXPENSES BY INSTITUTIONALIZED INDIVIDUALS.—Section 1902 (42 U.S.C. 1396), as amended by the amendment made by section 411(n)(3) of this Act, is amended by adding at the end the following new subsection:

42 USC 1396a

"(r) For purposes of sections 1902(a)(17) and 1924(d)(1)(D) and for purposes of a waiver under section 1915, with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver, there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

"(A) medicare and other health insurance premiums, deductibles, or coinsurance, and

"(B) necessary medical or remedial care recognized under State law but not covered under the State plan under this title, subject to reasonable limits the State may establish on the amount of these expenses.".

(e) CONFORMING AMENDMENT.—Section 1902 (42 U.S.C. 1396a), as amended by the amendment made by section 411(n)(3) of this Act, is amended—

(1) in subsection (a)(10)(C)(i)(III), by striking "the same" each place it appears and inserting "no more restrictive than the";

(2) by striking "and" at the end of subsection (a)(49);

(3) by striking the period at the end of subsection (a)(50) and inserting "; and";

(4) by inserting after paragraph (50) of subsection (a) the following new paragraph:

"(51)(A) meet the requirements of section 1924 (relating to protection of community spouses), and (B) meet the requirement of section 1917(c) (relating to transfer of assets).''; and

(5) in subsection (r), as added by subsection (d)—

(A) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively,

(B) by inserting "(1)" after "(r)", and

(C) by adding at the end the following new paragraph:

"(2)(A) The methodology to be employed in determining income and resource eligibility for individuals under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), (a)(10)(A)(ii), (a)(10)(C)(i)(III), or under subsection (f) may be less restrictive, and shall be no more restrictive, than the methodology—

"(i) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under title XVI, or

Blind persons. Handicapped persons.

"(ii) in the case of other groups, under the State plan most closely categorically related.

"(B) For purposes of this subsection and subsection (a)(10), methodology is considered to be 'no more restrictive' if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.".

(f) TREATMENT OF HOMESTEAD EXEMPTION IN MISSOURI.—The State medical assistance plan of Missouri shall not be in compliance with the requirements of title XIX of the Social Security Act as of October 1, 1989, unless such plan is amended to provide that, in determining the resources of any aged, blind, or disabled individual in the State who applies for medical assistance under such plan on or after such date, the State will not consider the home of the individual as a resource, regardless of the value of the home.

Blind persons. Handicapped persons.

(g) EFFECTIVE DATE.—

42 USC 1396r-5 note.

(1)(A) The amendments made by this section apply (except as provided in this subsection) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after September 30, 1989, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(B) Section 1924 of the Social Security Act (as inserted by subsection (a)) shall only apply to institutionalized individuals who begin continuous periods of institutionalization on or after September 30, 1989, except that subsections (b) and (d) of such section (and so much of subsection (e) of such section as relates to such other subsections) shall apply as of such date to individuals institutionalized on or after such date.

(2)(A) The amendment made by subsection (b) and section 1902(a)(51)(B) of the Social Security Act, apply (except as pro-

vided in paragraph (5)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1988, or the date of the enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(B) Section 1917(c) of the Social Security Act, as amended by subsection (b) of this section, shall apply to resources disposed of on or after July 1, 1988.

State and local governments.

(C) Notwithstanding subparagraphs (A) and (B), a State may continue to apply the policies contained in the State plan as of June 30, 1988, with respect to resources disposed of before July 1, 1988.

(3) The amendments made by subsection (c) shall apply to transfers occurring on or after July 1, 1988, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(4) The amendment made by subsection (d) is effective on and after April 8, 1988. The final rule of the Health Care Financing Administration published on February 8, 1988 (53 Federal Register 3586) is superseded to the extent inconsistent with the amendment made by subsection (d).

State and local governments.

(5) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section (other than subsection (e)), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(6) The amendments made by paragraphs (1) and (5) of subsection (e) shall apply to medical assistance furnished on or after October 1, 1982.

TITLE IV—UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE, OBRA TECHNICAL CORRECTIONS, AND MISCELLANEOUS PROVISIONS

Subtitle A—United States Bipartisan Commission on Comprehensive Health Care

SEC. 401. ESTABLISHMENT. 42 USC 1395b note.

There is established a commission to be known as the United States Bipartisan Commission on Comprehensive Health Care (in this title referred to as the "Commission").

SEC. 402. DUTIES. 42 USC 1395b note.

(a) IN GENERAL.—The Commission shall—

(1) examine shortcomings in the current health care delivery and financing mechanisms that limit or prevent access of all individuals in the United States to comprehensive health care, and

(2) make specific recommendations to the Congress respecting Federal programs, policies, and financing needed to assure the availability of—

(A) comprehensive long-term care services for the elderly and disabled,

(B) comprehensive health care services for the elderly and disabled, and

(C) comprehensive health care services for all individuals in the United States.

(b) CONSIDERATIONS IN RECOMMENDATIONS.—In making its recommendations, the Commission shall consider—

(1) the amount and sources (consistent with principles of social insurance) of Federal funds to finance the needed services, including reallocations of existing Federal program funds, and

(2) the most efficient and effective manner of administering such programs.

(c) DEFINITIONS.—In this title:

(1) The term "comprehensive health care services" includes—

(A) inpatient hospital services (including mental health services);

(B) skilled nursing facility services, intermediate care facility services, home health services, and other long-term health care services;

(C) physician services and other outpatient health care services (including mental health services);

(D) periodic general physical examinations, eye examinations, hearing examinations, dental examinations, foot examinations, and other preventive health care services; and

(E) prescription drugs, eyeglasses, hearing aids, orthopedic equipment, and dentures (both complete and partial).

(2) The term "comprehensive long-term care services" includes custodial and noncustodial services in facilities, as well as home and community-based services.

42 USC 1395b note.

SEC. 403. MEMBERSHIP.

(a) APPOINTMENT.—The Commission shall be composed of 15 members appointed as follows:

President of U.S.

(1) The President shall appoint 3 members.

(2) The President pro tempore of the Senate shall appoint, after consultation with the minority leader of the Senate, 6 members of the Senate, of whom not more than 4 may be of the same political party.

(3) The Speaker of the House of Representatives shall appoint, after consultation with the minority leader of the House of Representatives, 6 members of the House, of whom not more than 4 may be of the same political party.

(b) CHAIRMAN AND VICE CHAIRMAN.—The Commission shall elect a chairman and vice chairman from among its members.

(c) VACANCIES.—Any vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made and shall not affect the power of the remaining members to execute the duties of the Commission.

(d) QUORUM.—A quorum shall consist of 8 members of the Commission, except that 4 members may conduct a hearing under section 405(a).

(e) MEETINGS.—The Commission shall meet at the call of its chairman or a majority of its members.

(f) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—Members of the Commission are not entitled to receive compensation for service on the Commission. Members may be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Commission.

42 USC 1395b note.

SEC. 404. STAFF AND CONSULTANTS.

(a) STAFF.—The Commission may appoint and determine the compensation of such staff as may be necessary to carry out the duties of the Commission. Such appointments and compensation may be made without regard to the provisions of title 5, United States Code, that govern appointments in the competitive services, and the provisions of chapter 51 and subchapter III of chapter 53 of such title that relate to classifications and the General Schedule pay rates.

(b) CONSULTANTS.—The Commission may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Commission determines to be necessary to carry out the duties of the Commission.

42 USC 1395b note.

SEC. 405. POWERS.

(a) HEARINGS AND OTHER ACTIVITIES.—For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties.

(b) STUDIES BY GENERAL ACCOUNTING OFFICE.—Upon the request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

(c) COST ESTIMATES BY CONGRESSIONAL BUDGET OFFICE.—

(1) Upon the request of the Commission, the Director of the Congressional Budget Office shall provide to the Commission such cost estimates as the Commission determines to be necessary to carry out its duties.

(2) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under paragraph (1).

(d) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(e) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties.

(f) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies.

(g) OBTAINING INFORMATION.—The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 5, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

(h) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

(i) ACCEPTANCE OF DONATIONS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

SEC. 406. REPORT.

42 USC 1395b note.

(a) REPORT ON COMPREHENSIVE LONG-TERM CARE SERVICES FOR THE ELDERLY AND DISABLED.—The Commission shall submit to Congress a report, not later than 6 months after the date of the enactment of this Act, containing its findings and recommendations regarding comprehensive long-term care services for the elderly and disabled. The report shall include detailed recommendations for appropriate legislative initiatives respecting such services.

(b) REPORT ON COMPREHENSIVE HEALTH CARE SERVICES.—The Commission shall submit to Congress a report, not later than 1 year after the date of the enactment of this Act, containing its findings and recommendations regarding comprehensive health care services for the elderly and disabled and comprehensive health care services for all individuals in the United States. The report shall include detailed recommendations for appropriate legislative initiatives respecting such services.

SEC. 407. TERMINATION.

42 USC 1395b note.

The Commission shall terminate 30 days after the date of submission of the report required in section 406(b).

42 USC 1395b note.

SEC. 408. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated $1,500,000 to carry out this title.

Subtitle B—OBRA Technical Corrections

SEC. 411. TECHNICAL CORRECTIONS TO CERTAIN HEALTH CARE PROVISIONS IN THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987.

1 USC 106 note.

(a) REFERENCE TO OBRA AND EFFECTIVE DATES.—

(1) REFERENCE.—In this section, the term "OBRA" refers to the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203).

(2) EFFECTIVE DATE.—Except as specifically provided in this section, the amendments made by this section, as they relate to a provision in OBRA, shall be effective as if they were included in the enactment of that provision in OBRA.

(3) RATIFICATION OF ENROLLMENT CORRECTIONS AND PRINTED ENROLLMENT.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the enrollment corrections noted in footnotes numbered 9 through 72 of OBRA are hereby ratified and shall be considered to have been enacted as part of OBRA. The printed enrollment of title IV of OBRA, as prepared and printed under section 8004 of OBRA (including the footnote corrections described in subparagraph (B) and as incorporating the clarifications described in subparagraph (C)), shall be deemed to constitute title IV of OBRA as enacted.

42 USC 1320a-7b.

(B) FOOTNOTE CORRECTIONS.—(i) With respect to the reference to which footnote 28 relates (101 Stat. 1330-81), the reference shall be deemed to have read "1320a-7b)".

42 USC 1395m.

(ii) With respect to the word to which footnote 30 relates (101 Stat. 1330-91), the word shall be deemed to have read "the".

42 USC 1396b.

(iii) With respect to the designation to which footnote 52 relates (101 Stat. 1330-151), the designation shall be deemed to have read "(F)".

(C) CLARIFICATIONS OF ILLEGIBLE MATTER.—(i) Section 1842(n)(1)(A) of the Social Security Act, as added by section 4051(a) of OBRA (101 Stat. 1330-93), is deemed to have the phrase "the supplier's reasonable charge to individuals enrolled under this part for the test" immediately after "or, if lower, the".

42 USC 1395u.

(ii) Section 1834(a)(7)(B)(i) of the Social Security Act, as inserted by section 4062(b) of OBRA (101 Stat. 1330-103), is deemed to have a reference to "1987" immediately after "December".

42 USC 1395m.

(b) CORRECTIONS RELATING TO PART 1 OF SUBTITLE A OF TITLE IV (PART A OF THE MEDICARE PROGRAM).—

(1) SECTION 4002.—(A) Subclauses (III) and (IV) of section 1886(b)(3)(B)(i) of the Social Security Act, as amended by section 4002(a) of OBRA, are amended by striking "other hospitals" and inserting "for hospitals located in other urban areas".

42 USC 1395ww.

(B) Section 1886(b)(3)(B)(i)(IV) of the Social Security Act, as amended by section 4002(a) of OBRA, is amended by striking

"percent" each place it appears and inserting "percentage points".

(C) Section 1886(b)(3)(B)(i)(V) of the Social Security Act, as amended by section 4002(a) of OBRA, is amended by inserting "increase" after "market basket percentage". 42 USC 1395ww.

(D) The second sentence of section 1886(d)(2)(D) of the Social Security Act, as amended by section 4002(b) of OBRA, is amended by striking "the publication described in subsection (e)(5)(B)" and inserting "the publications described in subsection (e)(5)".

(E) Section 4002(c)(1)(B)(iii) of OBRA is amended, in the matter stricken, by striking the comma after "available". 42 USC 1395ww.

(F) Section 1886(d)(3)(A)(ii) of the Social Security Act, as amended by section 4002(c)(1)(C) of OBRA, is amended by striking "in urban areas" and inserting "in other urban areas". Urban areas.

(G) Section 1886(d)(1)(A)(iii) of the Social Security Act, as amended by section 4002(d) of OBRA, is amended by striking "if greater" and inserting "if the average standardized amount (described in clause (i)(I) or clause (ii)(I) of paragraph (3)(D)) for hospitals within the region of, and in the same rural, large urban, or other urban area as, the hospital is greater than the average standardized amount (described in the respective clause) for hospitals within the United States in that type of area". Urban areas. Rural areas.

(H)(i) Section 1886(d)(2)(D) of the Social Security Act is amended by striking the last sentence (added by section 4002(f)(1)(A) of OBRA).

(ii) Section 4002(f) of OBRA is amended by adding at the end the following new paragraph:

"(3) The second sentence of section 1813(b)(1) of the Social Security Act (42 U.S.C. 1395e(b)(1)) is amended by striking 'applicable percentage increase' and all that follows through 'is applied' and inserting 'Secretary's best estimate of the payment-weighted average of the applicable percentage increases (as defined in section 1886(b)(3)(B)) which are applied'.".

(iii) The amendment made by clause (ii) shall apply to the inpatient hospital deductible for years beginning with 1989. Effective date. 42 USC 1395e note.

(I) Section 4002(g) of OBRA is amended—

(i) in paragraph (1)(A), by striking "1886(a)(1)(A)(iii)" and inserting "1886(d)(1)(A)(iii)", 42 USC 1395ww note.

(ii) in paragraphs (1)(B) and (2)(B), by striking "1886(d)(3)(B)" and inserting "1886(b)(3)(B)", and

(iii) in paragraph (6), by striking "1886(d)(10)(B)" and inserting "1886(d)(1)(B)".

(2) SECTION 4003.—Section 4003(d) of OBRA is amended— 101 Stat.1330-46.

(A) in paragraph (2)—

(i) by inserting "(other than under section 1886(d)(5)(F) of such Act)" after "receives payments", and

(ii) by inserting "of such services" after "reasonable costs"; and

(B) in the matter following paragraph (2), by inserting "the" after "facilities of".

(3) SECTION 4004.—Section 4004(a) of OBRA is amended by inserting "(1)" after "SURVEY.—" and by adding at the end the following new paragraph: 42 USC 1395ww.

"(2) Section 1886(d)(9)(C)(iv) of such Act is amended by adding at the end the following new sentence: 'The second and third sentences Puerto Rico.

of paragraph (3)(E) shall apply to subsection (d) Puerto Rico hospitals under this clause in the same manner as they apply to subsection (d) hospitals under such paragraph and, for purposes of this clause, any reference in such paragraph to a subsection (d) hospital is deemed a reference to a subsection (d) Puerto Rico hospital.'.".

42 USC 1395ww.

(4) SECTION 4005.—(A) Section 1886(d)(8)(B) of the Social Security Act, as added by section 4005(a)(1)(D) of OBRA, is amended—

(i) by striking "The Secretary" and inserting "For purposes of this subsection, the Secretary", and

Rural areas.

(ii) by striking all that follows "if" and inserting the following: "the rural county would otherwise be considered part of an urban area, under the standards for designating Metropolitan Statistical Areas (and for designating New England County Metropolitan Areas) published in the Federal Register on January 3, 1980, if the commuting rates used in determining outlying counties (or, for New England, similar recognized areas) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous Metropolitan Statistical Areas (or New England County Metropolitan Areas).".

(B) Section 1886(d)(8)(C) of the Social Security Act, as added by section 4005(a)(1)(D) of OBRA, is amended by striking "standardized amount" and inserting "standardized amounts".

101 Stat. 1330-47.

(C) Section 4005(a) of OBRA is amended—

(i) in paragraph (1)(D), by striking "subparagraph" and inserting "subparagraphs", and

42 USC 1395ww note.

(ii) in paragraph (3), by striking "This section, and the amendments made by paragraph (1)," and inserting "This subsection".

42 USC 1395tt.

(D) Section 1883(d)(3) of the Social Security Act, as added by section 4005(b)(2)(B) of OBRA, is amended by inserting before the period at the end the following: ", except that such payment shall continue to be made in the period for those patients who are receiving extended care services at the time the hospital reaches the limit specified in this paragraph".

(5) SECTION 4006.—(A) Section 1886(g)(3)(A)(iv) of the Social Security Act, as amended by section 4006(a) of OBRA, is amended by inserting "for payments attributable" after "15 percent".

42 USC 1395ww.

(B) Section 4006(a) of OBRA is amended—

(i) by adding "and" at the end of subparagraph (A), and

(ii) by redesignating subparagraphs (A) and (B) as paragraphs (1) and (2), respectively.

42 USC 1395ww note.

(6) SECTION 4007.—Section 4007 of OBRA is amended—

(A) in the second sentence of subsection (a), by striking "updata" and inserting "updated";

(B) by amending subsection (b) to read as follows:

"(b) REQUIRING REPORTING OF STANDARDIZED COST REPORT ELECTRONICALLY.—

"(1) IN GENERAL.—Section 1886(f)(1) of the Social Security Act (42 U.S.C. 1395ww(f)(1)) is amended—

"(A) by striking ', for a period ending not earlier than September 30, 1988,',

"(B) by inserting '(A)' after '(f)(1)', and

"(C) by adding at the end the following new subparagraph:

" '(B)(i) Subject to clause (ii), the Secretary shall place into effect a standardized electronic cost reporting format for hospitals under this title.

" '(ii) The Secretary may delay or waive the implementation of such format in particular instances where such implementation would result in financial hardship (in particular with respect to hospitals with a small percentage of inpatients entitled to benefits under this title).'.

"(2) EFFECTIVE DATE.—The amendment made by paragraph (1)(C) shall apply to hospital cost reporting periods beginning on or after October 1, 1989."; and 42 USC 1395ww note.

(C) in subsection (c)— 42 USC 1395ww note.

(i) in paragraph (1)—

(I) by striking "3-year", and

(II) by striking "contracting" and inserting "conducting";

(ii) in paragraph (2), by striking "by category of service and" in subparagraphs (A) and (B);

(iii) in paragraph (2)(C), by striking "(by category of service)";

(iv) in paragraph (2), by striking subparagraph (D) and redesignating subparagraphs (E) through (L) as subparagraphs (D) through (K), respectively;

(v) by amending subparagraph (I), as so redesignated, to read as follows:

"(I) Bad debt and charity care.";

(vi) in paragraph (2), by adding at the end the following:

"The Secretary shall develop a definition of 'outpatient visit' for purposes of reporting hospital information.";

(vii) in paragraph (5), by striking "paragraph (3)" and inserting "paragraph (2)";

(viii) in paragraph (5)(A), by striking "The terms" and all that follows through "as" and inserting "The term 'bad debt and charity care' has such meaning as";

(ix) in paragraph (5)(B)—

(I) by inserting "at least" after "to payors",

(II) by striking "title VIII" and inserting "title XVIII", and

(III) by striking "self-paying individuals" and inserting "and other persons (including self-paying individuals)"; and

(x) in paragraph (6)—

(I) by striking "$1,000,000 for each of" and inserting "a total of $3,000,000 for",

(II) by inserting "or from operation funds" after "research funds",

(III) by striking ", and at least" and all that follows through "operations funds" and inserting "and", and

(IV) by striking "over 3 years".

(7) SECTION 4008.—Section 4008(d)(1)(B) of OBRA is amended by striking "1886" and inserting "1886(d)". 42 USC 1395ww note.

(8) SECTION 4009.—(A) Section 4009(a) of OBRA is amended— 42 USC 1395dd.

(i) by striking paragraphs (1) and (2) and inserting the following:

"(1) INCREASE IN CIVIL MONETARY PENALTY AND EXCLUSION OF RESPONSIBLE PHYSICIAN VIOLATORS.—Section 1867(d)(2) of the Social Security Act (42 U.S.C. 1395dd(d)(2)) is amended—

"(A) in the second sentence—

"(i) by redesignating such sentence as subparagraph (C),

"(ii) by striking 'previous sentence' and inserting 'this paragraph', and

"(iii) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively; and

"(B) by striking the first sentence and inserting the following: '(A) A participating hospital that knowingly violates a requirement of this section is subject to a civil money penalty of not more than $50,000 for each such violation. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1128A(a).

"'(B) The responsible physician in a participating hospital with respect to the hospital's violation of a requirement of this subsection is subject to the sanctions described in section 1842(j)(2), except that, for purposes of this subparagraph, the civil money penalty with respect to each violation may not exceed $50,000, rather than $2,000.' ";

42 USC 1395dd note.

and

(ii) by redesignating paragraph (3) as paragraph (2).

42 USC 1395ww.

(B) Section 4009(d)(1)(A) of OBRA is amended, in the matter inserted by such section, by striking the comma after "representatives".

42 USC 1395ww note.

(C) Section 4009(i) of OBRA is amended by striking "New England county metropolitan areas" and "4001(b)" and inserting "urban areas in New England" and "4002(b)", respectively.

(D) Section 4009(j) of OBRA is amended by adding at the end the following new paragraphs:

"(9) Section 1818(c) of the Social Security Act (42 U.S.C. 1395i-2(c)) is amended by striking paragraph (4) and redesignating paragraphs (5) through (7) as paragraphs (4) through (6), respectively.

"(10) Section 9305(d) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking '2 years after the date of the enactment of this Act' and inserting 'January 1, 1990'.".

100 Stat. 1988.

(c) CORRECTIONS RELATING TO SUBPART A OF PART 2 OF SUBTITLE A OF TITLE IV (HEALTH MAINTENANCE ORGANIZATION REFORMS).—

(1) SECTION 4011.—Subparagraph (F) of section 1876(c)(3) of the Social Security Act, as added by the amendment made by section 4011(a)(1) of OBRA, is amended by moving its indentation 4 ems to the left so its left margin is aligned with the left margin of subparagraph (G) of that section, as added by section 4011(b)(1) of OBRA.

42 USC 1395mm.

Contracts.

(2) SECTION 4012.—(A)(i) Section 1866(a)(1)(O) of the Social Security Act, as inserted by section 4012(a) of OBRA, is amended by striking "with a risk-sharing contract under section 1876" and inserting "(i) with a risk-sharing contract under section 1876, under section 1876(i)(2)(A) (as in effect before

42 USC 1395cc.

February 1, 1985), under section 402(a) of the Social Security Amendments of 1967, or under section 222(a) of the Social Security Amendments of 1972, and (ii) which does not have a contract establishing payment amounts for services furnished to members of the organization".

(ii) The amendment made by clause (i) shall apply to admissions occurring on or after the first day of the fourth month beginning after the date of the enactment of this Act. Effective date. 42 USC 1395cc note.

(B) Section 4012(c) of OBRA is amended by striking "paragraph (2)" and inserting "subsection (a)". 42 USC 1395mm note.

(3) SECTION 4013.—Section 4013 of OBRA is amended by striking "(a) IN GENERAL" and all that follows through the end and inserting the following: 42 USC 1395mm.

"Section 2350(b)(3) of the Deficit Reduction Act of 1984 is amended by striking 'four years after the date of the enactment of this Act' and inserting 'September 30, 1990'.". 42 USC 1395mm note.

(4) SECTION 4014.—Section 1876(i)(6) of the Social Security Act, as amended by section 4014 of OBRA, is amended— 42 USC 1395mm.

(A) in subparagraph (A), by inserting ", in addition to any other remedies authorized by law," after "the Secretary may provide", and

(B) in the last sentence of subparagraph (B), by striking "under that section" and inserting "or proceeding under section 1128A(a)".

(5) SECTION 4018.—Section 1876(f)(3)(A) of the Social Security Act, as inserted by section 4018(a) of OBRA, is amended—

(A) by inserting "enrollment and residency requirements under this section and for" after "for purposes of", and

(B) by striking "of the subdivision" and inserting "described in subparagraph (B)(iii) who receive services through the subdivision".

(d) CORRECTIONS RELATING TO SUBPART B OF PART 2 OF SUBTITLE A OF TITLE IV (HOME HEALTH QUALITY).—

(1) SECTION 4021.—(A) Section 1891(a) of the Social Security Act, as added by section 4021(b) of OBRA, is amended— 42 USC 1395bbb.

(i) in paragraph (3)(A), by striking "who is not a licensed health care professional (as defined in subparagraph (F))",

(ii) in paragraph (3)(F), by inserting "physical or occupational therapy assistant," after "occupational therapist,", and Health care professionals.

(iii) by striking paragraph (4) and by redesignating paragraphs (5) and (6) as paragraphs (4) and (5), respectively.

(B)(i) Section 1861(n) of the Social Security Act (42 U.S.C. 1395x(n)) is amended by inserting before the period at the end the following: "; except that such term does not include such equipment furnished by a supplier who has used, for the demonstration and use of specific equipment, an individual who has not met such minimum training standards as the Secretary may establish with respect to the demonstration and use of such specific equipment".

(ii) The amendment made by clause (i) shall apply to equipment furnished on or after the effective date provided in section 4021(c) of OBRA. Effective date.

(2) SECTION 4022.—(A) The third sentence of section 1891(c)(1) of the Social Security Act, as added by section 4022(a) of OBRA, is amended by inserting "(other than subsections (a) and (b))" after "1128A".

(B) Section 1891(d)(2)(A) of the Social Security Act, as added by section 4022(a) of OBRA, is amended by striking "1991" and inserting "1992".

42 USC 1395bbb.

42 USC 1395bbb.

(3) SECTION 4023.—(A) Section 4023 of OBRA is amended by inserting "(a) IN GENERAL.—" before "Section 1891".

(B) Section 1891(f)(2)(A) of the Social Security Act, as added by section 4023 of OBRA, is amended—

(i) by moving the indentation of clauses (i) through (iii) (and the sentence following clause (iii)) 2 ems to the left,

(ii) in clause (i), by striking "for each day of noncompliance" and inserting "in an amount not to exceed $10,000 for each day of noncompliance", and

(iii) by inserting after and below clause (iii), the following: "The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).".

(C) Section 4023(b) of OBRA is amended by inserting before the period at the end the following: ", and no intermediate sanction described in section 1891(f)(2)(A) of such Act shall be imposed for violations occurring before such effective date".

42 USC 1395aa.

(4) SECTION 4025.—(A) Section 1864(a) of the Social Security Act is amended—

(i) in the first sentence added by section 4025(a) of OBRA, by striking "most recent accreditation survey conducted with respect to the agency," and inserting "most recent accreditation survey conducted by a State agency or private accreditation agency under section 1865 with respect to the home health agency,", and

(ii) in the second sentence so added—

(I) by inserting "such State or local" before "agency" the first place it appears, and

(II) by striking "section 1864" and inserting "section 1865".

42 USC 1395aa note.

(B) Section 4025 of OBRA is amended—

(i) in subsection (b), by striking "subsection (a)" and inserting "this section" and by redesignating such subsection as subsection (c), and

(ii) by inserting after subsection (a) the following new subsection:

"(b) CONFORMING AMENDMENT.—The last sentence of section 1865(a) of such Act (42 U.S.C. 1395bb(a)) is amended by inserting '(other than a survey with respect to a home health agency' after 'any accreditation survey'.".

42 USC 1395x.

(5) SECTION 4026.—(A) Section 1861(v)(1)(L)(iii) of the Social Security Act, as added by section 4026(a)(1) of OBRA, is amended—

(i) by striking "audited" each place it appears and inserting "verified", and

(ii) by adding at the end the following:

Wages.

"In the case of a home health agency that refuses to provide data, or deliberately provides false data, respecting wages for purposes of this clause upon the request of the Secretary, the Secretary may withhold up to 5 percent of the amount of the payments otherwise payable to the agency under this title until such date as the Secretary determines that such data has been satisfactorily provided.".

(B) Section 4026(a)(2) of OBRA is amended by striking "July 1, 1988" and inserting "July 1, 1989". 42 USC 1395x note.

(C) Section 4026(b) of OBRA is amended by striking "June 1, 1988" and inserting "June 1, 1989".

(6) SECTION 4027.—Section 4027(a) of OBRA is amended by striking "July 1, 1988" and inserting "April 1, 1989". 42 USC 1395n note.

(e) CORRECTIONS RELATING TO SUBPART C OF PART 2 OF SUBTITLE A OF TITLE IV (OTHER MEDICARE PART A AND B PROVISIONS).—

(1) SECTION 4032.—(A) Section 4032 of OBRA is amended by striking "AND PHYSICIAN REVIEW" in the heading of subsection (a) and by striking "AND CARRIERS" in the heading of subsection (b). 42 USC 1395h.

(B) Section 1816(j)(2) of the Social Security Act, as added by section 4032(a) of OBRA, is amended— 42 USC 1395h.

(i) by inserting "in the case of a request for reconsideration of a denial," after "(2)", and

(ii) by inserting "the" before "disposition".

(C) Section 4032(c)(1)(B) of OBRA is amended by striking "claims filed" and inserting "reconsiderations requested". 42 USC 1395h note.

(2) SECTION 4033.—Section 4033 of OBRA is amended—

(A) by striking "(a) IN GENERAL.—"; 42 USC 426.

(B) by redesignating paragraphs (1) and (2) (and subparagraphs (A) and (B) of paragraph (2)) as subsections (a) and (b) (and paragraphs (1) and (2) of subsection (b)), respectively; and 42 USC 426 note.

(C) by aligning the left margins of the matter in such section flush left.

(3) SECTION 4039.—Section 4039 of OBRA is amended by adding at the end the following new subsection:

"(h) TECHNICAL CORRECTIONS.—

"(1) Section 1128A(b) of the Social Security Act (42 U.S.C. 1320a-7a(b)) is amended—

"(A) in paragraph (1)(A), by striking 'XVII' and inserting 'XVIII', and

"(B) in paragraph (2) by inserting 'each' after '$2,000 for'.

"(2) Section 1138(a)(1)(B) of such Act (42 U.S.C. 1320b-8(a)(1)(B)) is amended by striking 'In' and inserting 'in'.

"(3) Section 1154(a)(4) of such Act (42 U.S.C. 1320c-3(a)(4)) is amended—

"(A) by indenting subparagraphs (B) and (C) (and clauses (i) through (iii) of subparagraph (C)) two additional ems;

"(B) in subparagraph (B), by inserting 'risk-sharing' before 'contract under section 1876'; and

"(C) in subparagraph (C)(i), by adding before the comma at the end the following: '(other than the ability to perform review functions under this section that are not described in subparagraph (B))'.

"(4) Section 1154(d) of such Act (42 U.S.C. 1320c-3(d)) is amended by striking '1164(b)(4)' and inserting '1164'.

"(5) Section 1156(b) of such Act (42 U.S.C. 1320c-5(b)) is amended—

"(A) in the second sentence of paragraph (1), by striking 'such services on a reimbursable basis.' and inserting 'services under this Act on a reimbursable basis.', and

"(B) in paragraph (2), by striking 'at such time' and all that follows through 'and shall remain' and inserting 'on the same date and in the same manner as an exclusion

from participation under the programs under this Act becomes effective under section 1128(c), and shall remain'.

"(6) Section 1160 of such Act (42 U.S.C. 1320c-9) is amended by adding at the end the following new subsection:

" '(e) For purposes of this section and section 1157, the term "organization with a contract with the Secretary under this part" includes an entity with a contract with the Secretary under section 1154(a)(4)(C).'.

"(7) The heading of section 1870 of such Act (42 U.S.C. 1395gg) is amended to read as follows:

'OVERPAYMENT ON BEHALF OF INDIVIDUALS AND SETTLEMENT OF CLAIMS FOR BENEFITS ON BEHALF OF DECEASED INDIVIDUALS'.

"(8) Section 1876(i)(7) of such Act (42 U.S.C. 1395mm(i)(7)) is amended—

"(A) in subparagraph (A), by striking 'Except as provided under section 1154(a)(4)(C), each' and inserting 'Each';

"(B) in subparagraph (A), by inserting 'or with an entity selected by the Secretary under section 1154(a)(4)(C)' after 'located)'; and

"(C) by striking 'peer' in subparagraph (B) and the second place it appears in subparagraph (A).

"(9) Section 9353 of the Omnibus Budget Reconciliation Act of 1986 is amended—

42 USC 1320c-3 note.
Contracts.

"(A) in subsection (a)(6)(A)(i), by striking 'paragraphs (1) and (2)(D) shall apply to contracts as of' and inserting 'paragraph (1) shall apply to contracts entered into or renewed on or after';

"(B) in subsection (a)(6)(B), by striking 'amendment made by paragraph (2)(B)' and inserting 'amendments made by paragraphs (2)(B) and (2)(D)'; and

42 USC 1395mm note.
Contracts.

"(C) in subsection (e)(3)(B), by adding at the end the following: 'The provisions of section 1876(i)(7) of the Social Security Act (added by such amendment) shall apply to health maintenance organizations with contracts in effect under section 1876 of such Act (as in effect before the date of the enactment of Public Law 97-248) in the same manner as it applies to eligible organizations with risk-sharing contracts in effect under section 1876 of such Act (as in effect on the date of the enactment of this Act).'.".

(f) CORRECTIONS RELATING TO SUBPART A OF PART 3 OF SUBTITLE A OF TITLE IV (PAYMENTS FOR PHYSICIANS' SERVICES).—

42 USC 1395u.

(1) SECTION 4041.—(A) Section 4041(a)(1)(B) of OBRA is amended—

(i) by inserting "as amended retroactively by section 4085(i)(7)(C)," after "(j)(1)(C),", and

(ii) by redesignating the clause added by such section as clause (viii).

42 USC 1395u.

(B) The last sentence of section 1842(b)(2) of the Social Security Act, as added by section 4041(a)(3)(A) of OBRA, is amended by striking "and subsection (h)" and inserting ", subsection (h), and section 1845(f)(2)".

42 USC 1395u note.

(C) Subclause (II) of section 4041(a)(3)(B)(iii) of OBRA is amended to read as follows:

"(II) by striking 'April 1' and inserting 'September 30', and".

(2) SECTION 4042.—(A) Section 1842(b)(4)(F)(iii) of the Social Security Act, as added by section 4042(a) of OBRA, is amended— 42 USC 1395u.

(i) in subclause (I), by striking the semicolon and inserting a comma, and

(ii) in subclause (II), by striking "physician's" and inserting "physicians' ".

(B) Section 1842(b)(4)(F)(ii)(I) of the Social Security Act, as added by section 4042(a) of OBRA, is amended by striking "subparagraph (E)(iii)" and inserting "subsection (i)(4)".

(C) Section 4042(b) of OBRA is amended by striking "Section" and all that follows up to "The term" and inserting the following:

"(1) Section 1842 of such Act (42 U.S.C. 1395u) is amended—

"(A) in subsection (h)(7), by striking ', described in paragraph (8)';

"(B) in paragraph (8) of subsection (h)—

"(i) by striking '(8) For purposes of this title, a' and inserting '(1) A',

"(ii) by indenting such paragraph 2 ems, and

"(iii) by inserting before such paragraph the following:

" '(i) For purposes of this title:';

"(C) in subsection (b)(4)(E)—

"(i) by striking '(E) In this section:',

"(ii) by redesignating clauses (i) and (ii), as paragraphs (2) and (3), respectively, and

"(iii) by transferring and inserting such paragraphs, as redesignated, before subsection (j);

"(D) in subsection (b)(4), by redesignating subparagraphs (F) and (G) of subsection (b)(4), as subparagraphs (E) and (F), respectively; and

"(E) by inserting, after the paragraphs transferred and inserted by subparagraph (C)(iii), the following new paragraph:

" '(4)'.

(D) Section 4042(b) of OBRA is further amended by adding at the end the following: 42 USC 1395u.

"(2)(A) Section 1842(b)(4)(A)(vii) of such Act, as redesignated by sections 4041(a)(1)(A)(i) and 4044(a), is amended by striking 'subparagraph (E)(ii)' and inserting 'subsection (i)(3)'.

"(B) Section 1833(l)(2) of such Act (42 U.S.C. 1395l(l)(2)) is amended by striking '1842(b)(4)(E)(ii)' and inserting '1842(i)(3)'.".

(E) The last sentence of section 1842(b)(4)(A)(iv)(II) of the Social Security Act, as added by section 4042(c)(2) of OBRA, is amended by striking "January 1, 1988" and inserting "January 1, 1989".

(F) Section 4042(c) of OBRA is amended—

(i) by striking "Section" and all that follows up to "In the previous sentence" and inserting the following:

"(1) The first sentence of clause (iv) of section 1842(b)(4)(A) of such Act (42 U.S.C. 139u(b)(4)(A)) is amended to read as follows: 'The reasonable charge for physicians' services furnished on or after January 1, 1987, by a nonparticipating physician shall be no greater than the applicable percent of the prevailing charge levels established under the third and fourth sentences of paragraph (3) (or under any other applicable provision of law affecting the prevailing charge level).'.", and Effective date. Health care professionals.

(ii) by adding at the end the following:

Health care professionals. 42 USC 1395u.

"(2) Subclauses (I) and (II) of section 1842(j)(1)(C)(i) of such Act are amended by striking 'prevailing charge for the year involved for such service furnished by nonparticipating physicians' and inserting 'applicable percent (as defined in subsection (b)(4)(A)(iv)) of the prevailing charge for the year and service involved'.".

101 Stat. 1330-86.

(3) SECTION 4044.—(A) Section 4044(a) of OBRA is amended by striking "INCREASE IN PREVAILING CHARGES" and inserting "PREVAILING CHARGE FLOOR".

(B) Section 1842(b)(4)(A)(vi) of the Social Security Act, as inserted by section 4044(a) of OBRA, is amended— 42 USC 1395u.

(i) by striking "subparagraph (E)(iii)" and inserting "subsection (i)(4)",

(ii) by striking "the average of the prevailing charge levels" and inserting "the estimated average prevailing charge levels based on the best available data", and

(iii) by striking "for participating physicians".

(4) SECTION 4045.—(A) Section 1842(b)(10) of the Social Security Act, as amended by section 4045(a) of OBRA, is amended—

(i) in subparagraph (A)(i)—

(I) by striking "under paragraph (3)",

(II) by striking "subparagraph (C)" and inserting "subparagraph (B)", and

(III) by striking "for participating and nonparticipating physicians";

(ii) in subparagraph (A)(iii), by striking "clause (i)(II)" and inserting "clause (i)(I)";

(iii) in subparagraph (B) by inserting "(including subsequent insertion of an intraocular lens)" after "cataract surgery"; and

(iv) in subparagraph (D), by inserting "under" after "review".

42 USC 1395u.

(B) Section 4045(c)(2) of OBRA is amended—

(i) in subparagraph (B), by inserting before the period at the end the following: "and by striking the second sentence", and

(ii) by adding at the end the following new subparagraph:

"(D) The fourth sentence of section 1842(b)(3) of the Social Security Act (42 U.S.C. 1395u(b)(3)) is amended by inserting '(or under any other provision of law affecting the prevailing charge level)' after 'the level determined under this sentence'.".

(C) Section 1842(j)(1)(D)(iv) of the Social Security Act, as added by section 4045(c)(1)(B) of OBRA, is amended by striking "imposes a charge" and inserting "bills".

(D)(i) Section 1862(a)(15) of the Social Security Act (42 U.S.C. 1395y(a)(15)) is amended by inserting "(including subsequent insertion of an intraocular lens)" after "operation".

Effective date. 42 USC 1395y note.

(ii) The amendment made by clause (i) shall apply to operations performed on or after 60 days after the date of the enactment of this Act.

(5) SECTION 4046.—(A) Section 1842(b)(11)(C)(i) of the Social Security Act, as inserted by section 4046(a)(1)(C) of OBRA and as designated by section 4063(a)(1)(A), is amended by striking "implantation" and inserting "insertion".

(B) Section 1842(j)(1)(D)(ii)(IV) of the Social Security Act, as inserted by section 4046(a)(2)(A) of OBRA, is amended by striking "is". 42 USC 1395u.

(6) SECTION 4047.—(A) The heading of section 4047 of OBRA is amended by striking "**PRIMARY CARE**" and inserting "**CERTAIN**".

(B) Section 1842(b)(4)(G) of the Social Security Act, as added by section 4047(a) of OBRA, is amended—

(i) by inserting "than" after "(other", and

(ii) by striking "(as determined under the third and fourth sentences of paragraph (3) and under paragraph (4))".

(C) Section 4047(b) of OBRA is amended by inserting "on or" after "medicare beneficiaries". 42 USC 1395u note.

(D) The item in the table of contents of title IV of OBRA relating to section 4047 is amended to read as follows:

"Sec. 4047. Customary charges for certain services of new physicians.".

(7) SECTION 4048.—(A) Paragraph (14) of section 1842(b) of the Social Security Act, as added by section 4048(a) of OBRA, is redesignated as paragraph (13).

(B) Section 4048 of OBRA is amended by adding at the end the following new subsection: 101 Stat.1330-89.

"(e) CONFORMING AMENDMENT TO MAXIMUM ALLOWABLE ACTUAL CHARGE.—Section 1842(j)(1)(C) of the Social Security Act (42 U.S.C. 1395u(j)(1)(C)), as amended by sections 4085(i)(7)(C) and 4041(a)(1)(B) of this title, is amended by adding at the end the following new clause:

" '(ix) If there is a reduction under subsection (b)(13) in the reasonable charge for medical direction furnished by a nonparticipating physician, the maximum allowable actual charge otherwise permitted under this subsection for such services shall be reduced in the same manner and in the same percentage as the reduction in such reasonable charge.'.". Health care professionals.

(8) SECTION 4049.—(A) Section 1834(b)(6) of the Social Security Act, as added by section 4049(a)(2) of OBRA, is amended by striking "radiologic" each place it appears and inserting "radiology". 42 USC 1395m.

(B) Section 4049(a) of OBRA is amended—

(i) in paragraph (1), by striking "4062(c)(3)" and inserting "4062(d)(3)", and 42 USC 1395*l*.

(ii) in paragraph (2), by striking "4062(a)" and inserting "4062(b)". 42 USC 1395n.

(C) Section 1833(a)(1) of the Social Security Act, as amended by section 4049(a)(1) of OBRA, is amended in the clause added by that section by striking "1834(b)(5)" and inserting "1834(b)(6)". 42 USC 1395*l*.

(D) Section 1834(b) of the Social Security Act, as added by section 4049(a)(2) of OBRA, is amended—

(i) in the headings of paragraphs (4)(D) and (5), by inserting "AND SUPPLIERS" after "PHYSICIANS";

(ii) in paragraph (5)(C), by striking "imposes a charge" and inserting "bills";

(iii) in paragraph (5)(C), by inserting "in the same manner as such sanctions may apply to a physician" after "1842(j)(2)";

(iv) in paragraph (6), by striking ", section 1833(a)(1)(I), and section 1842(h)(1)(B)" and inserting "and section 1833(a)(1)(J)"; and

(v) in paragraph (6)(B), by striking "billings" and inserting "the total amount of charges".

42 USC 1395m note.

(E) Section 4049(b) of OBRA is amended by striking "establish" and inserting "propose".

42 USC 1395u.

(9) SECTION 4051.—Section 1842(n) of the Social Security Act, as added by section 4051(a) of OBRA, is amended—

(A) in paragraph (1) in the matter before subparagraph (A)—

(i) by striking "to a patient",

(ii) by inserting "the bill or request for" after "for which",

(iii) by striking "his" and inserting "a", and

(iv) by striking "supervised the test" and inserting "supervised the performance of the test";

(B) in paragraph (1)(A), by striking "to individuals enrolled under this part";

(C) in paragraph (2)(A), by inserting "the payment amount specified in paragraph (1)(A) and" after "other than"; and

(D) in paragraph (3), by striking "or supplier".

42 USC 1395ccc.

(10) FIRST SECTION 4052.—(A) Section 1892(a) of the Social Security Act, as added by the first section 4052(a) of OBRA, is amended—

(i) in paragraphs (2)(C)(ii) and (3)(B), by striking "paragraph (3)" and inserting "paragraph (4)",

(ii) in paragraph (4), by striking "bar" and inserting "exclude", and

(iii) in paragraph (4), by inserting before the period at the end the following: "if a State requests that the physician not be excluded".

42 USC 254o.

(B) The first section 4052(b) of OBRA (relating to conforming reference) is amended by striking "338E(b)(1)" and "254o(b)(1)" and inserting "338E(b)(1)(B)(i)" and "254o(b)(1)(B)(i)", respectively.

(C)(i) Section 1892 of the Social Security Act, as added by the first section 4052(a) of OBRA, is amended—

(I) in the heading, by striking "PHYSICIANS" and "SCHOLARSHIP" and inserting "INDIVIDUALS" and "SCHOLARSHIP AND LOAN", respectively;

(II) by striking "physician" each place it appears (other than the third place it appears in subsection (a)(4)) and inserting "individual";

(III) by striking "physician" the third place it appears in subsection (a)(4) and inserting "practitioner";

(IV) in paragraph (1)(A), by inserting ", the Physician Shortage Area Scholarship Program, or the Health Education Assistance Loan Program," after "Scholarship Program";

(V) in subsection (b), by striking ", and (2)" and all that follows through "Act" and inserting "or under subpart III of part F of title VII of such Act (as in effect before October 1, 1976) and which has not been paid by the deadline established by the Secretary pursuant to such respective section"; and

(VI) in subsection (b), by striking the period at the end and inserting "; or" and by adding at the end the following:

"(2) owed by an individual to the United States by reason of a loan covered by Federal loan insurance under subpart I of part C of title VII of the Public Health Service Act and payment for which has not been cancelled, waived, or suspended by the Secretary under such subpart.". Loans.

(ii) Section 733(f) of the Public Health Service Act (42 U.S.C. 294f(f)) is amended by adding at the end the following: "Procedures for reduction of payments under the medicare program are provided under section 1892 of the Social Security Act.".

(iii) The amendments made by this subparagraph shall be effective 30 days after the date of the enactment of this Act. Effective date. 42 USC 294f note.

(11) SECOND SECTION 4052.—(A) The second section 4052(a) of OBRA is amended by striking "is amended" and all that follows through the end and inserting the following: "is amended by inserting before the period at the end of the next-to-last sentence the following: ', and shall remain at such prevailing charge level until the prevailing charge for a year (as adjusted by economic index data) equals or exceeds such prevailing charge level'.". 42 USC 1395u.

(B) The second section 4052(b) of OBRA is amended by striking "January" and inserting "April". 42 USC 1395u note.

(12) SECTION 4054.—(A) Section 4054 of OBRA is amended to read as follows: 42 USC 1395*l* note.

"SEC. 4054. APPLYING COPAYMENT AND DEDUCTIBLE TO CERTAIN OUTPATIENT PHYSICIANS' SERVICES.

"(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended—

"(1) in subsection (a)(1), by striking clause (F),

"(2) in subsection (b), by striking paragraph (3) and by redesignating paragraphs (4) and (5) as paragraphs (3) and (4), respectively, and

"(3) in subsection (i), by striking paragraph (4).

"(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to services furnished on or after April 1, 1988.".

(B) The item relating to section 4054 in the table of contents of title IV of OBRA is amended to read as follows:

"Sec. 4054. Applying copayment and deductible to certain outpatient physicians' services.".

(13) SECTION 4055.—Section 4055 of OBRA is amended—

(A) in subsection (a)(2), by striking "such list" and inserting "such definitions", and 42 USC 1395u note.

(B) in subsection (b)(1), by striking "dermatology,". 42 USC 1395w-1 note.

(14) REDESIGNATION.—The second section 4052 of OBRA and sections 4053, 4054, and 4055 of OBRA are redesignated as sections 4053 through 4056, respectively. 42 USC 1395u, 1395u notes, 1395*l*, 1395*l* notes, 1395w-1 note.

(g) CORRECTIONS RELATING TO SUBPART B OF PART 3 OF SUBTITLE A OF TITLE IV (PAYMENTS FOR OTHER PART B SERVICES).—

(1) SECTION 4062.—(A) The heading of section 1834 of the Social Security Act, as inserted by section 4062(b) of OBRA, is amended by inserting "ITEMS AND" after "PARTICULAR". 42 USC 1395m.

(B) Subsection (a) of section 1834 of the Social Security Act, as so inserted, is amended—

(i) in paragraph (1)(C), by inserting "or under part A to a home health agency" after "under this part";

(ii) in the second sentence of paragraph (2)(A), by striking "rental" before "payments";

(iii) in paragraph (2)(B)(i), by striking "allowed" and inserting "reasonable", and in paragraphs (3)(B)(i) and (8)(A)(i)(I), by striking "allowable" and inserting "reasonable";

(iv) in paragraph (3)(A), by striking the extra space after "ventilators";

(v) in paragraph (4), by inserting after "individual patient" the following: ", and for that reason cannot be grouped with similar items for purposes of payment under this title,";

(vi) in paragraph (4), by inserting "(A)" after "in a lump-sum amount" and by inserting "(B)" after "for that item, and";

(vii) in paragraph (4), by striking "maintenance and service" each place it appears and inserting "maintenance and servicing", in paragraph (7)(A)(iii), by striking "service and maintenance" and inserting "maintenance and servicing", and in paragraphs (7)(A)(ii) and (11)(A), by striking "servicing" and inserting "maintenance and servicing";

(viii) in paragraph (7)(A)(iii)(I), by striking "fee established by the carrier" and inserting "fee or fees established by the Secretary ";

(ix) in paragraph (9)(A)(ii)(I), by striking "12-month period" and inserting "6-month period";

(x) in paragraph (9)(A)(ii)(II), by striking "and to 1991" and inserting ", 1991, and 1992";

(xi) in paragraphs (9)(B)(i) and (10)(B)(i), by striking the comma after "1991";

(xii) in paragraph (9)(C)(i), by striking "subparagraph (A)(ii)(I)" and inserting "subparagraph (A)(ii)";

(xiii) in paragraph (10)(B), by inserting before the period the following: "and payments under this subsection as such provisions apply to physicians' services and physicians and a reasonable charge under section 1842(b)";

(xiv) in the last sentence of paragraph (11)(A), by striking "under subsection (j)(2)" and inserting "under section 1842(j)(2)";

(xv) in paragraph (12), by striking "(as defined in section 1886(d)(2)(D))"; and

(xvi) by striking paragraph (14).

42 USC 1395m note.

(C) Section 4062(c)(4) of OBRA is amended—

(i) by inserting "and payment of a reasonable copying fee which the Secretary may establish" after "upon written request", and

(ii) by inserting before the period at the end the following: ", but only in a form which does not permit identification of individual suppliers".

42 USC 1395cc.

(D) The last sentence of section 1866(a)(2)(A) of the Social Security Act, as added by section 4062(d)(4) of OBRA, is amended by striking "section 1834(a)(2)" and inserting "section 1834(a)(1)(B)".

42 USC 1395*l*.

(E) The matter added by section 4062(d)(3)(A)(ii) of OBRA is amended by striking "and" before "(I)".

(2) SECTION 4063.—(A) Section 1842(b)(11)(C)(ii) of the Social Security Act, as amended by section 4063(a)(1)(A) of OBRA, is amended— 42 USC 1395u.

(i) by striking "implanted" and inserting "inserted", and

(ii) by inserting "or subsequent to" after "during".

(B) Subclause (IV) of section 1842(j)(1)(D)(ii) of the Social Security Act, as inserted by section 4063(a)(2)(A) of OBRA, is redesignated as subclause (V) and is amended by striking "is".

(C) Section 4063(a)(2)(B) of OBRA is amended by striking clause (ii) and by redesignating clauses (iii) and (iv) as clauses (ii) and (iii), respectively. 42 USC 1395*l*.

(D) Section 1833(i)(2)(A)(iii) of the Social Security Act, as inserted by section 4063(b)(3) of OBRA, is amended— 42 USC 1395*l*.

(i) by striking "implantation" and inserting "insertion", and

(ii) by inserting "or subsequent to" after "during".

(E) Section 4063 of OBRA is amended by adding at the end the following new subsection:

"(e) PREVENTION OF ADDITIONAL BILLINGS FOR IOLS.—

"(1) Section 1833(i) of the Social Security Act (42 U.S.C. 1395l(i)) is amended by adding at the end the following new paragraph:

" '(6) Any person, other than a facility having an agreement under section 1832(a)(2)(F)(i), who knowingly and willfully presents, or causes to be presented, a bill or request for payment, for an intraocular lens inserted during or subsequent to cataract surgery for which payment may be made under paragraph (2)(A)(iii), is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).'. Contracts. Claims. Law enforcement and crime.

"(2) Section 1832(a)(2)(F)(i) of such Act (42 U.S.C. 1395k(a)(2)(F)(i)) is amended by inserting '(including intraocular lens in cases described in section 1833(i)(2)(A)(iii))' after 'services' each place it appears.".

(3) SECTION 4064.—(A) Section 4064(a) of OBRA is amended by striking all that follows the first dash and inserting the following: "Paragraph (2) of section 1833(h) of the Social Security Act (42 U.S.C. 1395l(h)) is amended— 42 USC 1395*l* note.

"(1) by inserting '(A)(i)' after '(2)';

"(2) in the second sentence—

"(A) by redesignating clauses (A) and (B) as clauses (i) and (ii), respectively, and

"(B) by designating such sentence as subparagraph (B); and

"(3) by adding at the end of subparagraph (A)(i), as designated under paragraph (1), the following new clause:

" '(ii) Notwithstanding any other provision of this subsection—

" '(I) any change in the fee schedules which would have become effective under this subsection for tests furnished on or after January 1, 1988, shall not be effective for tests furnished during the 3-month period beginning on January 1, 1988, and

" '(II) the Secretary shall not adjust the fee schedules under clause (i) to take into account any increase in the consumer price index for 1988.'.".

(B) Section 4064(b)(1) of OBRA is amended—

(i) by striking "1833(h)(2) of the Social Security Act (42 U.S.C. 1395l(h)(2))" and inserting "1833(h)(2)(A) of the Social Security Act (42 U.S.C. 1395l(h)(2)(A)), as amended by subsection (a),";

(ii) by striking "the following: 'In establishing fee schedules under the first sentence of this paragraph with respect to" and inserting "the following new clause:

" '(iii) In establishing fee schedules under clause (i) with respect to"; and

(iii) by moving the indentation of all the matter added following "with respect to" 2 ems to the left.

42 USC 1395*l*.

(C) The clause added by section 4064(b)(1) of OBRA, as amended by subparagraph (A), is amended by inserting before the period at the end the following: ", and such reduced fee schedules shall serve as the base for 1989 and subsequent years".

42 USC 1395*l*.

(D) Section 1833(h)(4)(B)(ii) of the Social Security Act, as amended by section 4064(b)(2)(B) of OBRA, is amended by inserting "after" before "March".

(E) Section 4064(c) of OBRA is amended by striking all that follows the dash and inserting the following: "Section 1833(h)(1)(D) of such Act is amended by inserting ', in a sole community hospital (as defined in the last sentence of section 1886(d)(5)(C)(ii))' after 'a hospital laboratory'.".

(F) Section 4064(c) of OBRA is amended by inserting "(1)" after the dash and by adding at the end the following new paragraph:

Effective date.
42 USC 1395*l* note.

"(2) The amendment made by paragraph (1) shall apply with respect to diagnostic laboratory tests furnished on or after April 1, 1988.".

42 USC 1395w-2.

(G) Section 1846 of the Social Security Act, as added by section 4064(d)(1) of OBRA, is amended—

(i) in subsection (a)—

(I) by striking "certified" and "certification" and inserting "approved" and "approval", respectively,

(II) by inserting "or for coverage" after "conditions of participation", and

(III) by striking "cancelling immediately the certification of the provider or clinical laboratory" and inserting "terminating immediately the provider agreement or cancelling immediately approval of the clinical laboratory";

(ii) in subsections (b)(1)(A) and (b)(2)(A)(iv), by striking "certified";

Law enforcement and crime.

(iii) in subsection (b)(2)(A)(ii), by striking "civil fines and penalties" and inserting "civil money penalties in an amount not to exceed $10,000 for each day of substantial noncompliance";

(iv) in subsection (b)(2)(A), by adding at the end the following new sentence:

Law enforcement and crime.

"The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (ii) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).";

(v) in subsection (b)(2)(A)(iii), by striking "certification";

(vi) in subsection (b)(2)(A)(iv), by striking "provided on or after the date in" and inserting "furnished on or after the date on"; and

(vii) in subsection (b)(3), by striking "fines" and inserting "penalties" each place it appears.

(H) The matter inserted in section 1861(s) of the Social Security Act by section 4064(e)(1) of OBRA is amended by inserting a comma after "year". 42 USC 1395x.

(4) SECTION 4066.—(A) The heading of section 4066 of OBRA is amended by inserting "AND OTHER DIAGNOSTIC TESTS" after "RADIOLOGY".

(B) The item relating to section 4066 in the table of contents of title IV of OBRA is amended to read as follows:

"Sec. 4066. Payments to hospital outpatient departments for radiology and other diagnostic tests.".

(C) Section 1833(n) of the Social Security Act, as added by section 4066(a)(2) of OBRA, is amended— 42 USC 1395*l*.

(i) in paragraph (1)(A), by striking "beginning on or after October 1, 1988, under this part for services described in subsection (a)(2)(E)" and inserting "for services described in subsection (a)(2)(E)(i) furnished under this part on or after October 1, 1988, and for services described in subsection (a)(2)(E)(ii) furnished under this part on or after October 1, 1989,";

(ii) in paragraph (1)(B)(i)(II), by inserting "or (for services described in subsection (a)(2)(E)(i) furnished on or after January 1, 1989) the fee schedule amount established" after "the prevailing charge"; and

(iii) by amending subclauses (I) and (II) of paragraph (1)(B)(ii) to read as follows:

"(I) The term 'cost proportion' means 50 percent, except that such term means 65 percent in the case of outpatient radiology services for portions of cost reporting periods which occur in fiscal year 1989 and in the case of diagnostic procedures described in subsection (a)(2)(E)(ii) for portions of cost reporting periods which occur in fiscal year 1990.

"(II) The term 'charge proportion' means 100 percent minus the cost proportion.".

(5) SECTION 4067.—Section 1833(f) of the Social Security Act, as inserted by section 4067(a) of OBRA, is amended by striking "medicare economic index (referred to in the fourth sentence of section 1842(b)(3)) applicable to physicians' services" and inserting "MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4))".

(6) SECTION 4068.—The last sentence of section 1135(d)(3) of the Social Security Act, as added by section 4068(b)(1) of OBRA, is amended by striking "speciality" and inserting "specialty". 42 USC 1320b-5.

(h) CORRECTIONS RELATING TO SUBPART B OF PART 3 OF SUBTITLE A OF TITLE IV (PART B ELIGIBILITY AND BENEFITS CHANGES).—

(1) SECTION 4070.—(A) The last sentence of section 1833(c) of the Social Security Act, as added by section 4070(a)(2) of OBRA, is amended by striking "prescribing or monitoring prescription drugs" and inserting "monitoring or changing drug prescriptions". Prescription drugs.

(B) Section 1861(ff) of the Social Security Act, as added by section 4070(b)(2) of OBRA, is amended—

(i) by inserting before such subsection the following heading:

"Partial Hospitalization Services", and

(ii) in paragraph (3), by striking "hospital-based or hospital-affiliated (as defined by the Secretary)" and inserting "furnished by a hospital to its outpatients".

(2) SECTION 4071.—Section 1861(s)(10)(A) of the Social Security Act, as amended by section 4071(a) of OBRA, is amended by inserting ", subject to section 4071(b) of the Omnibus Budget Reconciliation Act of 1987," before "influenza vaccine". 42 USC 1395x.

(3) SECTION 4072.—(A) Section 1861(s)(12) of the Social Security Act, as amended by section 4072(a) of OBRA, is amended by inserting "subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987," after "(12)".

(B) Section 4072(b) of OBRA is amended— 42 USC 1395*l*.

(i) by striking "by inserting after subsection (e)" and inserting "by adding at the end, as previously amended,", and

(ii) by redesignating the subsection added by such section as subsection (o).

(4) SECTION 4073.—Section 4073 of OBRA is amended—

(A) by striking paragraph (1) of subsection (b); 42 USC 1395k.

(B) in paragraph (2) of subsection (b)— 42 USC 1395*l*.

(i) by redesignating such paragraph as paragraph (1);

(ii) by inserting "and" at the end of subparagraph (A);

(iii) by striking subparagraph (B);

(iv) in the matter added by subparagraph (C)—

(I) by striking "and (I)" and inserting "(K)",

(II) by inserting "80 percent of the lesser of the actual charge for the services or" after "amounts paid shall be",

(III) by striking "but in no event more than" and inserting "but in no event shall such fee schedule exceed", and

(IV) by striking the semicolon and inserting a comma; and

(v) by redesignating subparagraph (C) as subparagraph (B);

(C) in paragraph (3) of subsection (b)—

(i) by inserting ", as previously amended," after "at the end",

(ii) by redesignating such paragraph as paragraph (2),

(iii) by redesignating the subsection added by such paragraph as subsection (p), and

(iv) by adding at the end of the subsection added by such paragraph the following: "Except for deductible and coinsurance amounts applicable under section 1833, whoever knowingly and willfully presents, or causes to be presented, to an individual enrolled under this part a bill or request for payment for services described in the previous sentence, is subject to a civil money penalty of not to exceed $2,000 for each such bill or request. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).";

Claims.
Law enforcement and crime.

(D) in the subsection added by subsection (c)— 42 USC 1395x.
(i) by redesignating such subsection as subsection (gg), and
(ii) in paragraph (1), by striking "his" and inserting "the nurse-midwife's" and by striking "physician's" and inserting "physicians' "; and
(E) in the matter inserted by subsection (d)(1), by striking "section 1861(ff)" and inserting "section 1861(gg)". 42 USC 1396d.

(5) SECTION 4074.—Section 4074 of OBRA is amended— 42 USC 1395x.
(A) in the matter inserted by subsection (a)(1), by striking "(ff)" and inserting "(hh)", and
(B) by redesignating the subsection added by subsection (b) as subsection (hh).

(6) SECTION 4076.—Subsection (a) of section 4076 of OBRA is amended to read as follows:

"(a) SERVICES COVERED.—Section 1861(s)(2)(K) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)) is amended by inserting '(I)' before 'in a hospital' and by striking 'or as an assistant at surgery' and inserting ', (II) as an assistant at surgery, or (III) in a rural area (as defined in section 1886(d)(2)(D)) that is designated, under section 332(a)(1)(A) of the Public Health Service Act, as a health manpower shortage area,'.". Rural areas.

(7) SECTION 4077.—Section 4077(b) of OBRA is amended—
(A) in paragraph (1), by inserting "by section 4073(a) of this title" after "as amended"; 42 USC 1395x.
(B) by striking paragraph (2); 42 USC 1395k.
(C) in paragraph (3)— 42 USC 1395l.
(i) by striking "1395k(a)(1))" and inserting "1395l(a)(1)),
(ii) by striking subparagraphs (A) and (B),
(iii) in subparagraph (C), by striking "(I)" and inserting "(K)" and by redesignating such subparagraph as subparagraph (A),
(iv) in subparagraph (D), by striking "subparagraph:" and inserting "clause:" and by redesignating such subparagraph as subparagraph (B), and
(v) in the matter added by subparagraph (B), as so redesignated—
(I) by striking "(J)" and inserting "(L)", and
(II) by inserting "80 percent of the lesser of the actual charge for the services or" after "amounts paid shall be";
(D) in paragraph (4), by striking "section 4073(b)(3)" and inserting "4073(b)(2)"; 42 USC 1395l.
(E) in paragraph (5), by redesignating the subsection (gg) added by such paragraph as subsection (ii); and 42 USC 1395x.
(F) by redesignating paragraphs (3) through (6) as paragraphs (2) through (5), respectively. 42 USC 1395l, 1395x, 1395k note.

(8) SECTION 4079.—Section 4079(c)(1) of OBRA is amended by striking "subsection (d)" and inserting "subsection (e)". 42 USC 1395mm note.

(i) PROVISIONS RELATING TO SUBPART D OF PART 3 OF SUBTITLE A OF TITLE IV (OTHER PART B PROVISIONS).—

(1) SECTION 4081.—(A) Section 1842(h)(3)(B) of the Social Security Act, as added by section 4081(a) of OBRA, is amended— 42 USC 1395u.
(i) in the second sentence—
(I) by striking "claims" and inserting "payment", and

(II) by striking "including such information as the Secretary determines is generally provided" and inserting "shall include an explanation of benefits and any additional information that the Secretary may determine to be appropriate in order";

(ii) in the third sentence, by striking "arrangements" and inserting "agreements"; and

(iii) in the fourth sentence—

(I) by inserting "by a carrier" after "under this subparagraph", and

(II) by inserting before the period at the end the following: ", and such user fees shall be collected and retained by the carrier".

42 USC 1395ss.

(B) Section 4081(b)(2) of OBRA is amended by redesignating subparagraphs (A) through (C) as subparagraphs (B) through (D), respectively, and by inserting before subparagraph (B), as so redesignated, the following:

"(A) in the matter before paragraph (1), by inserting '(or, with respect to paragraph (3), the issuer of the policy)' after 'he finds that such policy',".

42 USC 1395ss.

(C) Section 1882(c)(3) of the Social Security Act, as inserted by section 4081(b)(2)(C) of OBRA, is amended—

(i) in subparagraph (A), by striking "claims form" each place it appears and inserting "claim form" in the first 2 places and "notice" in the third place,

(ii) in subparagraph (B)(i), by inserting "under the policy" after "payment determination", and

(iii) in subparagraph (B)(ii), by striking "appropriate payment" and inserting "payment covered by such policy".

42 USC 1395ss note.

(D) Section 4081(c)(2)(B)(i) of OBRA is amended by striking "medical" and inserting "medicare".

(E) Section 4081(c)(2)(B)(ii) of OBRA is amended by inserting "or which has not enacted such legislation before July 1, 1988," after "in which such legislation may be considered".

42 USC 1395u.

(2) SECTION 4082.—Section 4082(c) of OBRA is amended—

(A) by striking "1842(b)(5) of such Act (42 U.S.C. 1395u(b)(5)" and inserting "1842(b)(2) of such Act (42 U.S.C. 1395u(b)(2))", and

(B) in paragraph (1), by striking "(5)" and inserting "(2)".

(3) SECTION 4084.—Section 4084 of OBRA is amended by adding at the end the following new subsection:

"(c) ADDITIONAL TECHNICAL CORRECTIONS.—

"(1) Section 1861(bb)(2) of the Social Security Act (42 U.S.C. 1395x(bb)(2)) is amended by adding at the end the following: 'Such term also includes, as prescribed by the Secretary, an anesthesiologist assistant.'.

"(2) Section 1833(a)(1)(H) of such Act (42 U.S.C. 1395l(a)(1)(H)) is amended by striking 'lesser of the actual charge' and inserting 'least of the actual charge, the prevailing charge that would be recognized if the services had been performed by an anesthesiologist,'.

Effective date. 42 USC 1395l note.

"(3) The amendments made by this subsection shall apply to services furnished after December 31, 1988.".

42 USC 1395w-1.

(4) SECTION 4085.—(A) Section 1845(f) of the Social Security Act, as added by section 4085(a) of OBRA, is amended—

(i) in paragraph (1), by striking "October 1st" and inserting "December 31st", and

(ii) in paragraph (2), by striking "July 1st of the following year" and inserting "the later of (A) July 1st of the following year, or (B) 45 days after the date of a reasonable charge update".

(B) Subparagraph (D) of section 1833(h)(5) of the Social Security Act, as added by section 4085(b)(1) of OBRA, is amended— 42 USC 1395*l*.

(i) by striking "If a person" and all that follows through "under subparagraph (C)" and inserting the following: "A person may not bill for a clinical diagnostic laboratory test performed by a laboratory, other than a rural health clinic, other than on an assignment-related basis. If a person knowingly and willfully and on a repeated basis bills for a clinical diagnostic laboratory test in violation of the previous sentence", and

(ii) by striking "section 1842(j)(2)" and inserting "paragraphs (2) and (3) of section 1842(j) in the same manner such paragraphs apply with respect to a physician".

(C) Section 4085(i) of OBRA is amended—

(i) in the matter inserted by paragraph (1)(A), by inserting a comma after "assignment-related basis"; 42 USC 1395*l*.

(ii) in paragraph (1), by striking subparagraph (B);

(iii) in paragraph (11), by striking "9367(a)" and inserting "4072(a)"; 42 USC 1395*x*.

(iv) in paragraph (21)(D)(i), by inserting "by" after "(i)"; 42 USC 1395*l*.

(v) in paragraph (21)(D)(ii), by striking "and by" and all that follows up to the semicolon; and 42 USC 1395*l* note.

(vi) by adding at the end the following:

"(22)(A) Section 1832(a)(2)(F)(ii) of the Social Security Act (42 U.S.C. 1395k(a)(2)(F)(ii)) is amended by striking 'an assignment described in section 1842(b)(3)(B)(ii)' and inserting 'payment on an assignment-related basis'.

"(B) Section 1833(h)(5) of such Act (42 U.S.C. 1395l(h)(5)) is amended, in each of subparagraphs (A) and (C), by striking 'on the basis of an assignment' and all that follows through '1870(f)(1),' and inserting 'on an assignment-related basis'.

"(C) Section 1842(b)(7)(B)(iii) of such Act (42 U.S.C. 1395u(b)(7)(B)(ii)) is amended by striking 'the basis of' and all that follows through '1870(f)(1)' and inserting 'an assignment-related basis'.

"(23) Section 1833(l)(5)(B)(ii) of such Act (42 U.S.C. 1395k(l)(5)(B)(ii)) is amended— 42 USC 1395*l*.

"(A) in the first sentence by striking 'monetary' and inserting 'money', and

"(B) by amending the second sentence to read as follows: 'The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).'.

"(24) The fourth sentence of section 1842(b)(3) of such Act (42 U.S.C. 1395u(b)(3)) is amended by striking 'physician services' and 'physicians services' and inserting 'physicians' services' in both places.

"(25) Section 1842(b)(12)(C) of such Act (42 U.S.C. 1395u(b)(12)(C)) is amended—

"(A) in the first sentence by striking 'monetary' and inserting 'money', and

"(B) by amending the second sentence to read as follows: 'The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).'.

"(26) Section 1842(j)(2) of such Act (42 U.S.C. 1395u(j)(2)(B)) is amended—

"(A) by striking 'title' each place it appears and inserting 'Act', and

"(B) in subparagraph (B)—

"(i) by striking 'the imposition of',

"(ii) by inserting 'and assessments' after 'such penalties', and

"(iii) by amending the second sentence to read as follows: 'The provisions of section 1128A (other than the first 2 sentences of subsection (a) and other than subsection (b)) shall apply to a civil money penalty and assessment under subparagraph (B) in the same manner as such provisions apply to a penalty, assessment, or proceeding under section 1128A(a), except to the extent such provisions are inconsistent with subparagraph (A) or paragraph (3).'.

"(27) Section 1842(l)(1)(C)(i) of such Act (42 U.S.C. 1395u(l)(1)(C)(i)) is amended by inserting 'the physician establishes that' after '(i)'.

"(28) Section 1866(g) of such Act (42 U.S.C. 1395cc(g)) is amended—

"(A) in the first sentence by striking 'monetary' and inserting 'money', and

"(B) by amending the second sentence to read as follows: 'The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).'.".

(D)(i) Section 1862(e) of the Social Security Act (42 U.S.C. 1395y(e)) is amended—

(I) by striking "or section 1128A" and inserting ", 1128A, 1156, 1842(j)(2), or 1867(d)",

(II) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), and

(III) by inserting "(1)" after "(e)".

(ii) Section 1890 of the Social Security Act, as added by section 10 of Public Law 100-93, is amended— 42 USC 1395aaa.

(I) by striking its heading;

(II) by striking "SEC. 1890" and inserting "(2)";

(III) by inserting "1842(j)(2)," before "1862(d),";

(IV) by striking "or 1866" and inserting "1866, or 1867(d)"; and

(V) by transferring and adding such provision at the end of section 1862(e) of such Act. 42 USC 1395y.

(j) CORRECTIONS TO PART 4 OF SUBTITLE A OF TITLE IV (RELATING TO PEER REVIEW ORGANIZATIONS).—

(1) SECTION 4091.—Section 4091(a)(1)(B) of OBRA is amended by striking "renewals occurring" and inserting "contracts expiring". 42 USC 1320c-2 note.

(2) SECTION 4093.—Section 1154(a)(3) of the Social Security Act, as amended by section 4093(a) of OBRA, is amended by amending the last sentence to read as follows: 42 USC 1320c-3. Health care professionals.

"(C) The discussion and review conducted under subparagraph (B)(ii) shall not affect the rights of a practitioner or provider to a formal reconsideration of a determination under this part (as provided under section 1155).".

(3) SECTION 4094.—(A) Section 4094(a) of OBRA is amended by striking "subparagraph (B)" and inserting "subparagraph (A)". 42 USC 1320c-3.

(B) Section 1154(a)(15) of the Social Security Act, as added by section 4094(b) of OBRA, is amended by striking "at at" and inserting "in at".

(4) SECTION 4096.—(A) Section 4096(a)(1)(A) of OBRA is amended by striking "(b)(3)(ii)" and inserting "(b)(3)(B)(ii)". 42 USC 1395u.

(B) Section 1870(f) of the Social Security Act, as amended by section 4096(a)(2) of OBRA, is amended by striking "specified in subclauses (I) and (II) of" and inserting "of assignment specified in". 42 USC 1395gg.

(C) Sections 1154(e)(3)(A)(i) and 1154(e)(3)(B) (42 U.S.C. 1320c-3(e)(3)(A)(i), 1320c-3(e)(2)(B)), as amended by section 4096(c) of OBRA, are each amended by striking "or (2)" before "paragraph (2)".

(5) SECTION 4097.—Section 4097(b) of OBRA is amended by striking "1866(a)(4)(C)(ii) of such Act (42 U.S.C. 1395cc(a)(4)(C)(ii))" and inserting "1866(a)(3)(C)(ii) of such Act (42 U.S.C. 1395cc(a)(3)(C)(ii))". 42 USC 1395cc.

(k) CORRECTIONS TO SUBTITLE B OF TITLE IV (RELATING TO MEDICAID).—

(1) TABLE OF CONTENTS.—The table of contents of title IV of OBRA is amended by striking the item relating to section 4105 and by redesignating the items relating to sections 4106 and 4107 as relating to sections 4105 and 4106, respectively.

(2) SECTION 4101.—Section 1916(c)(1) of the Social Security Act, as inserted by section 4101(d)(1)(C) of OBRA, is amended by striking "nonfarm". 42 USC 1396o.

(3) SECTION 4102.—(A) Section 1915(d)(5)(B) of the Social Security Act, as amended by section 4102(a)(1)(B) of OBRA, is amended— 42 USC 1396n.

(i) in clause (iii)(III), by striking "75" and inserting "65", and

(ii) by inserting before "Effective on" the following: "The Secretary shall develop (by not later than October 1, 1989) a method for projecting, on a State-specific basis, the percentage increase in the number of residents in each State who are over 75 years of age for any period.".

(B) Section 1915(d)(5)(C)(i) of the Social Security Act, as amended by section 4102(a)(1)(B) of OBRA, is amended—

(i) by striking "(4)(B)," and inserting "(4), and", and

(ii) by striking ", and services furnished" and all that follows through "subsection (c)".

(4) SECTION 4103.—Section 1905(a)(5)(B) of the Social Security Act, as inserted by section 4103(a) of OBRA, is amended by striking "subparagraph" and inserting "clause". 42 USC 1396d.

(5) SECTION 4104.—(A) Paragraph (1) of section 4104(1) of OBRA is amended to read as follows: 42 USC 1396a.

"(1) by striking ', or' at the end of subclause (IX) and inserting a semicolon and by inserting 'or' at the end of subclause (X); and".

(B) Section 1902(a)(10)(A)(ii)(XI) of the Social Security Act, as added by section 4104(2) of OBRA, is amended—

42 USC 1396a.

(i) by striking "are more restrictive" and inserting "may be more restrictive", and

(ii) by striking the period at the end and inserting a semicolon.

42 USC 1396a note.

(6) SECTION 4112.—(A) Section 4112 of OBRA is amended—

(i) in subsection (a)(2)(A)—

(I) by striking "such date" and inserting "April 1, 1989", and

Effective date.

(II) by inserting ", effective for inpatient hospital services provided on or after July 1, 1989" before the period;

(ii) in subsection (a)(2)(B)—

(I) by striking "such date" and inserting "April 1, 1990", and

Effective date.

(II) by inserting ", effective for inpatient hospital services provided on or after July 1, 1990" before the period;

(iii) the undesignated paragraph at the end of subsection (a) is amended—

State and local governments.

(I) by striking "June 30 of each year in which the State is required to submit" and inserting "90 days after the date a State submits",

(II) by indenting all of such paragraph 2 ems, and

(III) by designating the first two sentences thereof as paragraph (3) and the last sentence thereof as paragraph (4);

(iv) in subsection (b)(2), by striking "the State plan" and inserting "a State plan";

(v) in subsection (b)(3)(B)(i), by inserting ", less the portion of any cash subsidies described in clause (i)(II) in the period reasonably attributable to inpatient hospital services" after "charity care in a period";

(vi) in subsection (c)—

(I) by striking "paragraphs (2)(A) and (2)(B)" and inserting "paragraphs (1)(B) and (2)(A) of subsection (a)",

(II) by striking "paragraph (2)(A)" and "paragraph (2)(B)" and inserting "such paragraph (1)(B)" and "such paragraph (2)(A)", respectively,

(III) in paragraph (1), by inserting "at least" after "equal to",

(IV) in paragraph (2), by inserting "(without regard to the election made by a State under subsection (b)(1))" after "payment) and",

(V) in the matter after paragraph (2), by inserting "at least" before "one-third" and before "two-thirds", and

Children and youth.

(VI) by adding at the end the following new sentences: "In the case of a hospital described in subsection (d)(2)(A)(i) (relating to children's hospitals), in computing the hospital's disproportionate share adjustment percentage for purposes of paragraph (1)(B) of this subsection, the disproportionate patient percent-

age (defined in section 1886(d)(5)(F)(vi)) shall be computed by substituting for the fraction described in subclause (I) of such section the fraction described in subclause (II) of that section. If a State elects in a State plan amendment under subsection (a) to provide the payment adjustment described in paragraph (2), the State must include in the amendment a detailed description of the specific methodology to be used in determining the specified additional payment amount (or increased percentage payment) to be made to each hospital qualifying for such a payment adjustment and must publish at least annually the name of each hospital qualifying for such a payment adjustment and the amount of such payment adjustment made for each such hospital."; and

State and local governments.

(vii) in subsection (e)—

(I) by inserting "(1)" after "SPECIAL RULE.—",

(II) by inserting "based on a pooling arrangement involving a majority of the hospitals participating under the plan" after "payment adjustments", and

(III) by adding at the end the following new paragraph:

"(2) In the case of a State that used a health insuring organization before January 1, 1986, to administer a portion of its plan on a Statewide basis, during the 3-year period beginning on July 1, 1988—

State and local governments. Effective date.

"(A) the requirements of subsections (b) and (c) shall not apply if the aggregate amount of the payment adjustments under the plan for disproportionate share hospitals (as defined under the State plan) is not less than the aggregate amount of payment adjustments otherwise required to be made if such subsections applied, and

"(B) subsection (d)(2)(B) shall apply to hospitals located in urban areas, as well as in rural areas.".

Urban areas. Rural areas.

(B) Section 4112 of OBRA is further amended—

42 USC 1396a note.

(i) by striking "(a) IMPLEMENTATION OF REQUIREMENT.—" and inserting the following:

"(a) IN GENERAL.—Title XIX of the Social Security Act is amended—

"(1) by redesignating section 1923 as section 1924, and

42 USC 1396s.

"(2) by inserting after section 1922 the following new section:

"'ADJUSTMENT IN PAYMENT FOR INPATIENT HOSPITAL SERVICES FURNISHED BY DISPROPORTIONATE SHARE HOSPITALS

"'SEC. 1923. (a) IMPLEMENTATION OF REQUIREMENT.—";

42 USC 1396r-4.

(ii) in subsection (a)(1), by striking "A State's plan under title XIX of the Social Security Act" and inserting "A State plan under this title";

(iii) in subsection (a)(1), by striking "of such Act";

(iv) in subsection (a), by striking "of Health and Human Services" each place it appears;

(v) in the matter following paragraph (2)(B) of subsection (a), by striking "of the Social Security Act";

(vi) in subsections (b) and (c), by striking "under title XIX of the Social Security Act" each place it appears and inserting "under this title";

(vii) in subsection (d)(2)(B), by striking "of the Social Security Act";

(viii) in subsections (b)(2), (b)(3), and (d)(2)(B), by striking double quotation marks enclosing terms and inserting single quotation marks;

(ix) by placing opening double quotation marks at the beginning of any matter with an initial paragraph indentation (beginning with subsection (a)(1)) and closing double quotation marks at the end of subsection (e); and

(x) by adding at the end the following:

Disadvantaged persons.

"(b) CONFORMING AMENDMENT.—Section 1903(i)(3) of such Act (42 U.S.C. 1396b(i)(3)) is amended by inserting '(other than amounts attributable to the special situation of a hospital which serves a disproportionate number of low income patients with special needs)' before 'to the extent'.".

(7) SECTION 4113.—Section 4113 of OBRA is amended—

42 USC 1396b.

(A) in the matter inserted by subsection (a)(1)(B)—

(i) by moving the left margin of the matter 2 ems to the left, and

(ii) by striking "subparagraph (G)" and inserting "subparagraph (E) or (G)";

42 USC 1396a.

(B) in the matter inserted by subsection (a)(2), by striking "paragraph (2)(G) or (6)" and inserting "paragraph (2)(B)(iii), (2)(E), (2)(G), or (6)";

42 USC 1396a.

(C) in subsection (b)(2)(ii), by striking "such"; and

42 USC 1396a, 1396b.

(D) by striking subsection (d) and redesignating subsection (e) as subsection (d).

42 USC 1396d.

(8) SECTION 4114.—(A) Section 4114 of OBRA is amended in paragraph (1), by striking " '(1)' " and inserting " '(o)(1)' ".

42 USC 1396d.

(B) Section 1905(o)(1)(B) of the Social Security Act, as added by section 4114(3) of OBRA, is amended—

(i) by striking "only", and

(ii) by striking "immunodeficiency syndrome" and inserting "immune deficiency syndrome (AIDS)".

101 Stat. 1330-153.

(9) SECTION 4115.—(A) Section 4115 of OBRA is amended—

(A) in subsection (b)(4)(B), by striking "program" and inserting "Program",

(B) in subsection (c)—

(i) by inserting "under section 9121 of this Act" after "Upon approval", and

(ii) by striking "1916, and 1924" and inserting "1902(e)(1), and 1916", and

(C) by adding at the end the following:

"(d) EXTENSION OF TEXAS STATE WAIVER.—Section 9523(a) of the

100 Stat. 217.

Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking 'January 1, 1989' and inserting 'January 1, 1990'.".

(10) SECTION 4118.—(A) Section 1915(c)(10) of the Social Security Act, as added by section 4118(b) of OBRA, is amended—

42 USC 1396n.

(i) by striking "No waiver under this subsection shall limit by an amount less than 200" and inserting "The Secretary shall not limit to fewer than 200", and

(ii) by striking "under such waiver" and inserting "under a waiver under this subsection".

42 USC 1320a-7a note.

(B) Section 4118(e) of OBRA is amended—

(i) in paragraph (3), by striking "amendment" and inserting "amendments", and

(ii) in paragraph (1)—

(I) by inserting "(A)" after "(1)",

(II) by striking "1128A(a)(1)" and "1320a-7(a)(1))" and inserting "1128(a)" and "1320a-7(a))", respectively, and 42 USC 1320a-7a, 1320a-7.

(III) by adding at the end the following:

"(B) Section 1128A of such Act is amended by adding at the end the following new subsection: 42 USC 1320a-7a.

" '(l) A principal is liable under this section for the actions of the principal's agent acting within the scope of the agency.' ".

(C) Section 1128(d)(3)(B)(ii) of the Social Security Act, as added by section 4118(e)(2)(B) of OBRA, is amended by striking "under a program". 42 USC 1320a-7.

(D) Section 4118(e) of OBRA is amended by redesignating paragraph (3) as paragraph (14) and by inserting after paragraph (2) the following new paragraphs: 42 USC 1320a-7a note.

"(3) Section 1128(b)(8)(A)(i) of such Act is amended by inserting after '(A)(i)' the following: 'who has a direct or indirect ownership or control interest of 5 percent or more in the entity or'.

"(4) Section 1128(d) of such Act is amended—

"(A) in paragraph (1), by striking 'subsection (b)' and inserting 'this section and section 1128A', and

"(B) in paragraph (3)(A), by striking 'under a program'.

"(5) Section 1128(i) of such Act is amended—

"(A) in the matter before paragraph (1), by striking 'a physician or other individual' and inserting 'an individual or entity',

"(B) in paragraphs (1) through (4), by striking 'physician or other individual' each place it appears and inserting 'individual or entity', and

"(C) in paragraph (4), by striking 'first offender or other program' and inserting 'first offender, deferred adjudication, or other arrangement or program'.

"(6) Section 1128A(a)(1)(D) of such Act is amended— 42 USC 1320a-7a.

"(A) by striking 'excluded under' and inserting 'excluded from', and

"(B) by inserting 'or as a result of the application of the provisions of section 1842(j)(2) or section 1867(d)(2)' after 'or 1866(b)'.

"(7) The second sentence of section 1128A(c)(1) of such Act is amended—

"(A) by inserting ', request for payment, or other occurrence described in this section' after 'any claim', and

"(B) by inserting ', the request for payment was made, or the occurrence took place' after 'claim was presented'.

"(8) Section 1128A(i) of such Act is amended, in the matter before paragraph (1), by striking 'subsection' and inserting 'section'.

"(9) Section 1128A(i)(1) of such Act is amended by inserting 'or title XX' after 'title V'.

"(10) Section 1128A of such Act is further amended—

"(A) in the matter in subsection (a) before paragraph (1), by inserting ', but excluding a beneficiary, as defined in subsection (i)(5)' after 'other entity',

"(B) in subsection (i)(2), by striking 'submitted by' and all that follows through the end and inserting 'for payments for items and services under title V, XVIII, XIX, or XX of this Act.', and

"(C) by adding at the end the following new paragraph:

" '(5) The term "beneficiary" means an individual who is eligible to receive items or services for which payment may be made under title V, XVIII, XIX, or XX but does not include a provider, supplier, or practitioner.'.

"(11) Section 1903(i)(2) of such Act (42 U.S.C. 1396b(i)(2)) is amended—

"(A) in subparagraph (A), by striking 'in the State plan under this title pursuant to section 1128 or section 1128A' and inserting 'under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, 1842(j)(2), or 1867(d)(2)', and

"(B) in subparagraph (B), by striking 'pursuant to section 1128 or section 1128A from participation in the program under this title' and inserting 'from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, 1842(j)(2), or 1867(d)(2)'.

"(12) Section 504(b)(6) of such Act (42 U.S.C. 704(b)(6)) is amended by striking 'pursuant to section 1128 or section 1128A from participation in the program under this title' each place it appears and inserting 'under this title or title XVIII, XIX, or XX pursuant to section 1128, 1128A, 1156, 1842(j)(2), or 1867(d)(2)'.

"(13) Section 2005(a)(9) of such Act (42 U.S.C. 1397d(a)(9)) is amended by striking 'pursuant to section 1128 or section 1128A from participation in the program under this title' each place it appears and inserting 'under this title or title V, XVIII, or XIX pursuant to section 1128, 1128A, 1156, 1842(j)(2), or 1867(d)(2)'.".

42 USC 1396j.

(E) Section 4118(f)(1) of OBRA is amended by striking "4111(g)(8)" and inserting "4211(h)(8)".

(F) Section 4118(g)(1)(B) of OBRA is amended by striking "insert" and inserting "inserting".

(G) Section 4118(h) of OBRA is amended—

(i) by inserting a dash after "EXPENSES.";

(ii) in paragraph (1), by striking "Section 1902(a)(17) of the Social Security Act (42 U.S.C. 1396a(a)(17)) is amended" and inserting "Sections 1902(a)(17) and 1903(f)(2) of the Social Security Act (42 U.S.C. 1396a(a)(17), 1396b(f)(2)) are each amended";

42 USC 1396a note.

(iii) in paragraph (2), by striking "(2) The amendment made by paragraph (1)" and inserting "(3) The amendments made by this subsection", and

(iv) by inserting after paragraph (1) the following new paragraph:

State and local governments.

"(2) The first sentence of section 1902(f) of such Act (42 U.S.C. 1396a(f)) is amended by inserting after 'as recognized under State law' the following: 'regardless of whether such expenses are reimbursed under another public program of the State or political subdivision thereof'.".

42 USC 1396n.

(H) Section 1915(c)(7)(B) of the Social Security Act, as added by section 4118(k) of OBRA, is amended by inserting before the period at the end the following: ", without regard to the availability of beds for such inpatients".

42 USC 1396n.

(I) Section 4118(l)(1) of OBRA is amended by inserting ", as redesignated by section 4102(a)," after "1396n(h))".

(J) Section 9414(b)(3) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 4118(o)(1)(C) of OBRA, is amended by striking "nonfarm".

(K) Section 4118(o)(2)(A) of OBRA is amended by inserting "each place it appears" before "and inserting".

(L) Section 4118(p)(9) of OBRA is amended by striking "1925(a)" and "(4111(a))" and inserting "1923(a)" and "4211(a)", respectively. 42 USC 1396s.

(M) Section 4118(p) of OBRA is amended by adding at the end the following new paragraph:

"(11) Paragraph (5) of section 9432(c) of the Omnibus Budget Reconciliation Act of 1986 is amended to read as follows: 42 USC 1396a note.

" '(5) The Secretary shall submit an interim report on the results of the study, including an analysis of the geographic variations under paragraph (2), to the Congress not later than January 1, 1990, and shall report the final results of the study to the Congress not later than January 1, 1992.'.". Reports.

(11) OMITTED SECTION.—(A) Part 2 of subtitle B of title IV of OBRA is amended by adding at the end the following new section:

"SEC. 4119. STUDY OF MEANS OF RECOVERING COSTS OF NURSING FACILITY SERVICES FROM ESTATES OF BENEFICIARIES.

"The Secretary of Health and Human Services shall study the means of recovering amounts from estates of deceased medicaid beneficiaries (or the estates of the spouses of such deceased beneficiaries) to pay for the medical assistance for skilled nursing facility or intermediate care facility services furnished, under title XIX of the Social Security Act, to such medicaid beneficiaries. The Secretary shall report to Congress, not later than December 31, 1988, on such means, and include appropriate recommendations for changes in legislation.". Reports.

(B) The table of contents of title IV of OBRA is amended by inserting after the item relating to section 4118 the following new item:

"Sec. 4119. Study of means of recovering costs of nursing facility services from estates of beneficiaries.".

(12) MEDICAID CONFORMING AMENDMENT TO SECTION 4014 OF OBRA.—(A) Paragraph (5) of section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)) is amended to read as follows:

"(5)(A) If the Secretary determines that an entity with a contract under this subsection— Contracts.

"(i) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

"(ii) imposes premiums on individuals enrolled under this subsection in excess of the premiums permitted under this title;

"(iii) acts to discriminate among individuals in violation of the provision of paragraph (2)(A)(v), including expulsion or refusal to re-enroll an individual or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this subsection) by eligible individuals with the organization whose medical condi-

tion or history indicates a need for substantial future medical services; or

"(iv) misrepresents or falsifies information that is furnished—

"(I) to the Secretary or the State under this subsection, or

"(II) to an individual or to any other entity under this subsection,

the Secretary may provide, in addition to any other remedies available under law, for any of the remedies described in subparagraph (B).

Law enforcement and crime.

"(B) The remedies described in this subparagraph are—

"(i) civil money penalties of not more than $25,000 for each determination under subparagraph (A), or, with respect to a determination under clause (iii) or (iv)(I) of such subparagraph, of not more than $100,000 for each such determination, plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iii), $15,000 for each individual not enrolled as a result of a practice described in such subparagraph, or

State and local governments. Contracts.

"(ii) denial of payment to the State for medical assistance furnished under the contract under this subsection for individuals enrolled after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).".

Effective date. 42 USC 1396b note.

(B) The amendment made by subparagraph (A) shall apply to actions occurring on or after the date of the enactment of this Act.

(13) TREATMENT OF EDUCATIONALLY-RELATED SERVICES.—(A) Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by inserting after subsection (b) the following new subsection:

Children and youth. Handicapped persons.

"(c) Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a handicapped child because such services are included in the child's individualized education program established pursuant to part B of the Education of the Handicapped Act or furnished to a handicapped infant or toddler because such services are included in the child's individualized family service plan adopted pursuant to part H of such Act.".

Effective date. 42 USC 1396b note.

(B) The amendment made by subparagraph (A) shall take effect on the date of the enactment of this Act.

(14) CLARIFICATION OF TERM "INSTITUTION FOR MENTAL DISEASES".—(A) Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended by inserting after subsection (h) the following new subsection:

"(i) The term 'institution for mental diseases' means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of

persons with mental diseases, including medical attention, nursing care, and related services.".

(B) The amendment made by subparagraph (A) shall take effect on the date of the enactment of this Act. Effective date. 42 USC 1396d note.

(15) ELIGIBILITY VERIFICATION TECHNICAL CORRECTION.—(A) Section 1137 of the Social Security Act (42 U.S.C. 1320b-7) is amended by adding at the end the following new subsection:

"(f) Subsections (a)(1) and (d) shall not apply with respect to aliens seeking medical assistance for the treatment of an emergency medical condition under section 1903(v)(2).". Aliens.

(B) The amendment made by subparagraph (A) shall apply as if it were included in the enactment of section 9406 of the Omnibus Budget Reconciliation Act of 1986. Effective date. 42 USC 1320b-7 note.

(16) TECHNICAL CORRECTIONS RELATING TO PRESUMPTIVE ELIGIBILITY.—(A) Section 1920(d)(1)(B) of the Social Security Act (42 U.S.C. 1396r-1(d)(1)(B)) is amended by striking "by a qualified provider" and inserting "by a provider that is eligible for payments under the State plan".

(B) Section 1920(b)(2)(D) of such Act (42 U.S.C. 1396r-1(b)(2)(D)) is amended—

(i) in clause (i)—

(I) in subclause (I), by striking "or section 330" and inserting ", 330, or 340" and by striking "or" at the end,

(II) in subclause (II), by striking the semicolon at the end and inserting ", or", and

(III) by adding after subclause (II) the following new subclause:

"(III) title V of the Indian Health Care Improvement Act;";

(ii) in clause (ii), by striking "or" at the end; and

(iii) by adding at the end the following new clause:

"(iv) is the Indian Health Service or is a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638).". Indians.

(C) The amendments made by this paragraph shall be effective as if they were included in section 9407(b) of the Omnibus Budget Reconciliation Act of 1986. Effective date. 42 USC 1396r-1 note.

(17) WAIVER FOR CHILDREN INFECTED WITH AIDS OR DRUG DEPENDENT AT BIRTH.—(A) Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended—

(i) by redesignating subsection (f) as paragraph (2);

(ii) in subsection (e), by striking paragraph (2) and by redesignating such subsection as subsection (f);

(iii) by inserting after subsection (d) the following new subsection:

"(e)(1)(A) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this title shall include as 'medical assistance' under such plan payment for part or all of the cost of nursing care, respite care, physicians' services, prescribed drugs, medical devices and supplies, transportation services, and such other services requested by the State as the Secretary may approve which are provided pursuant to a written plan of care to a child described in subparagraph (B) with respect to whom there has been a determination that but for the provision of such services the infants would be likely to require the level of care provided in a State and local governments. Prescription drugs. Children and youth. Transportation.

hospital or nursing facility the cost of which could be reimbursed under the State plan.

"(B) Children described in this subparagraph are individuals under 5 years of age who—

AIDS.

"(i) at the time of birth were infected with (or tested positively for) the etiologic agent for acquired immune deficiency syndrome (AIDS),

"(ii) have such syndrome, or

Drugs and drug abuse.

"(iii) at the time of birth were dependent on heroin, cocaine, or phencyclidine,

and with respect to whom adoption or foster care assistance is (or will be) made available under part E of title IV.

State and local governments.

"(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

Public health and safety.

"(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

"(B) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

"(C) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

"(3) A waiver granted under this subsection may include a waiver of the requirements of section 1902(a)(1) (relating to statewideness) and section 1902(a)(10)(B) (relating to comparability). A waiver under this subsection shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met.

"(4) The provisions of paragraph (6) of subsection (d) shall apply to this subsection in the same manner as it applies to subsection (d).";

and

(iv) in subsection (h), by striking "or (d)" and inserting "(d), or (e)".

(B) Section 1902(a)(10)(A)(ii)(VI) of such Act (42 U.S.C. 1396a(a)(10)(A)(ii)(VI)) is amended by striking "(c) or (d)" each place it appears and inserting "(c), (d), or (e)".

(l) CORRECTIONS RELATING TO SUBTITLE C OF TITLE IV (NURSING HOME REFORM).—

(1) SECTION 4201.—(A) Section 1819 of the Social Security Act, as added by section 4201(a)(3) of OBRA, is amended—

42 USC 1395i-3.

(i) in subsection (b)(3)(C)(i)(I), by striking "October 1, 1990" the second place it appears and inserting "January 1, 1991";

(ii) in subsection (b)(4)(C)(i)—

(I) by inserting "licensed" after "24-hour",

(II) by striking "employ" and inserting "use", and

(III) by striking "during the day tour of duty (of at least 8 hours a day)" and inserting "at least 8 consecutive hours a day,";

(iii) in subsection (b)(5)(A), by striking "October 1, 1989" and all that follows through "July 1, 1989)" and inserting "January 1, 1990";

(iv) in subsection (e)(1)(A), by striking "March 1, 1989" and inserting "January 1, 1989";

(v) in subsection (e)(1)(B), by striking "March 1, 1990" and inserting "January 1, 1990";

(vi) in subsection (e)(2)(A), by striking "March 1, 1989" and inserting "January 1, 1989";

(vii) in subsection (e)(3), by striking "October 1, 1990" and inserting "October 1, 1989";

(viii) in subsection (e)(5), by striking "July 1, 1989" and inserting "July 1, 1990";

(ix) in subsection (f)(3), by striking "October 1, 1989" and inserting "October 1, 1988";

(x) in subsection (f)(5)(A), by striking "July 1, 1989" and inserting "January 1, 1989"; and

(xi) in subsection (f)(6)(B), by striking "October 1, 1990" and inserting "April 1, 1990".

(B) Section 4201(d) of OBRA is amended— 42 USC 1395x.

(i) by striking "AMENDMENT.—" and inserting "AMENDMENTS.—(1)",

(ii) by striking "1919(a)(2)" and inserting "1819(a)(1)", and

(iii) by adding at the end the following new paragraph:

"(2) Section 1861(n) of such Act (42 U.S.C. 1395x(n)) is amended by striking 'or (j)(1) of this section' and inserting 'or of section 1819(a)(1)'.".

(2) SECTIONS 4201 AND 4211.—(A) Sections 1819(b)(3)(A)(iv) and 1919(b)(3)(A)(iv) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are amended by striking "in the case of a resident eligible for benefits under part A of this title" and by striking "in the case of a resident eligible for benefits under part A of title XVIII", respectively. 42 USC 1395i-3, 1396r.

(B) Sections 1819(b)(3)(A)(iii) and 1919(b)(3)(A)(iii) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are amended by striking "in the case of a resident eligible for benefits under title XIX," and "in the case of a resident eligible for benefits under this title,", respectively.

(C) Subclause (III) of each of sections 1819(b)(3)(B)(ii) and 1919(b)(3)(B)(ii) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, is amended to read as follows:

"(III) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).".

(D) Sections 1819(b)(5) and 1919(b)(5) of the Social Security Act, as added by section 4201(a)(3) of OBRA and as inserted by section 4211(a)(3) of OBRA, respectively, are each amended—

(i) in subparagraph (A), by striking ", who is not a licensed health care professional (as defined in subparagraph (E))",

(ii) in subparagraph (A)(ii), by striking "such services" and inserting "nursing or nursing-related services", and

(iii) in subparagraph (G), by inserting "physical or occupational therapy assistant," after "occupational therapist,".

Effective date.
42 USC 1395x note.
42 USC 1395x.

(E) Effective as of the date of the enactment of this Act and until the effective date of section 1819(c) of such Act, section 1861(j) of the Social Security Act is deemed to include the requirement described in section 1819(c)(3)(A) of such Act (as added by section 4201(a)(3) of OBRA).

(F) Sections 1819(c)(2)(A)(v) and 1919(c)(2)(A)(v) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are each amended by striking "an allowable charge" and all that follows through the semicolon and inserting "for a stay at the facility;".

42 USC 1395i-3, 1396r.

(G) Sections 1819(c)(6) and 1919(c)(6) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are each amended—

(i) in subparagraph (A)(ii), by striking "once the facility accepts" and inserting "upon", and

(ii) in subparagraph (B), by striking "a facility's acceptance of".

(H) Sections 1819(e)(2)(B) and 1919(e)(2)(B) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively are each amended by inserting after the first sentence the following sentence: "The State shall make available to the public information in the registry.".

State and local governments.
Public information.
Records.

(I) Sections 1819(e)(3), 1819(f)(3), 1919(e)(3), and 1919(f)(3) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, are each amended—

(i) by inserting "AND DISCHARGES" after "TRANSFERS", and

(ii) by inserting "and discharges" after "transfers".

(J) Sections 1819(f)(2)(A)(i)(I) and 1919(f)(2)(A)(i)(I) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are each amended by striking "cognitive, behavioral and social care" and inserting "recognition of mental health and social service needs".

(K) Sections 1819(f)(7) and 1919(f)(7) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are each amended by striking "patients" and inserting "residents".

(L)(i) Section 1819(f)(7)(B) of the Social Security Act, as added by section 4201(a)(3), is amended by striking "shall not" and inserting "shall".

(ii) Section 1919(f)(7)(B) of the Social Security Act, as inserted by section 4211(a)(3) of OBRA, is amended by striking "do not".

(3) SECTION 4211.—(A) Section 1919(b)(4)(C) of the Social Security Act, as inserted by section 4211(a) of OBRA, is amended—

(i) by striking "registered nurse" each place it appears and inserting "registered professional nurse";

(ii) by striking "employ" and inserting "use";

(iii) by striking "(ii) FACILITY WAIVERS.—" and all that follows through "(i) WAIVER" and inserting "(ii) WAIVER";

(iv) by striking "and subject to clause (ii)" and inserting "and subject to clause (iii)";

(v) by striking "(ii) ASSUMPTION" and inserting "(iii) ASSUMPTION"; and

(vi) in clause (iii), as so redesignated, by striking "excercise" and inserting "exercise".

(B) Section 1919(b)(5)(A) of the Social Security Act, as added by section 4211(a)(3) of OBRA, is amended by striking "subparagraph (E)" and inserting "subparagraph (F)". 42 USC 1396r.

(C) Effective as of the date of the enactment of this Act and until the effective date of section 1919(c) of such Act, section 1905(c) of the Social Security Act is deemed to include the requirement described in section 1919(c)(3)(A) of such Act (as inserted by section 4211(a)(3) of OBRA). Effective date. 42 USC 1396d.

(D) Section 1919 of the Social Security Act, as inserted by section 4211(a)(3) of OBRA, is amended—

(i) in subsection (e)(1)(A), by striking "September 1, 1988" and inserting "January 1, 1989";

(ii) in subsection (e)(1)(B), by striking "September 1, 1990" and inserting "January 1, 1990";

(iii) in subsection (e)(7)(E), by striking "October 1, 1988" and inserting "April 1, 1989"; and

(iv) in subsection (f)(2), by striking "July 1, 1988" and inserting "September 1, 1988".

(E) Section 1902(a)(28)(D)(i) of the Social Security Act, as amended by section 4211(b)(1)(B) of OBRA, is amended by striking "1919(f)" and all that follows through "instrument)" and inserting "1919(e)". 42 USC 1396a.

(F) Section 4211(d)(2) of OBRA is amended by striking "For calendar quarters during fiscal years 1988 and 1989" and inserting "For the 8 calendar quarters (beginning with the calendar quarter that begins on July 1, 1988)". Effective date. 42 USC 1396b note.

(G) Section 4211(h)(10)(G) of OBRA is amended by adding before the period at the end the following: ", and by striking 'skilled nursing facility or intermediate care facility' in subparagraph (B) and inserting 'nursing facility' ". 42 USC 1396n.

(H) Section 4211(h)(2) of OBRA is amended— 42 USC 1396a.

(i) in subparagraph (C), by striking "inserting 'nursing facilities' " each place it appears and inserting "inserting 'nursing facilities and for intermediate care facilities for the mentally retarded' ",

(ii) in subparagraph (D)(i), by striking "inserting 'nursing facility' " and inserting "inserting 'nursing facility or intermediate care facility for the mentally retarded' ", and

(iii) in subparagraph (D)(ii), by striking "inserting 'nursing facility' " and inserting "inserting 'nursing facility services or services in an intermediate care facility for the mentally retarded' ".

(I) Subparagraph (B) of section 4211(h)(12) of OBRA is amended to read as follows: 42 USC 1396p.

"(B) in subsection (c)(2)(B)(ii), by striking 'skilled' each place it appears.".

(4) SECTION 4202.—Section 1819(g)(2)(C)(i) of the Social Security Act, as added by section 4202(a) of OBRA, is amended by striking "October 1, 1990" and inserting "January 1, 1990". 42 USC 1395i-3.

(5) SECTIONS 4202 AND 4212.—Sections 1819(g) and 1919(g) of the Social Security Act, as added by sections 4202(a)(2) and 4212(a) of OBRA, respectively, are amended— 42 USC 1395i-3, 1396r.

(A) in paragraph (1)(C), by striking ", review," and inserting "and timely review";

(B) in the first sentence of paragraph (1)(C), by inserting "or by another individual used by the facility in providing services to such a resident" after "a nursing facility";

(C) by striking the second sentence of paragraph (1)(C) and inserting the following: "The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the appropriate licensure authority."; State and local governments. Health care professionals.

(D) in paragraph (1)(D), by striking "to establish standards under subsection (f)" and inserting "to issue regulations to carry out this subsection";

(E) in paragraph (2)(A)(i), by amending the third sentence to read as follows: "The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).";

(F) in paragraph (3)(D) (relating to special surveys of compliance, as redesignated by paragraph (6)(A) in the case of section 1919(g)), by striking "on that basis" and inserting "on the basis of that survey"; and

(G) in paragraph (4), by striking "chronically".

(6) SECTION 4212.—(A) Section 1919(g)(3) of the Social Security Act, as added by section 4212(a) of OBRA, is amended by redesignating the second subparagraph (C) (relating to special surveys of compliance) as subparagraph (D).

(B) Section 4212(b) of OBRA is amended to read as follows: 42 USC 1395aa, 1396r.

"(b) POSTING SURVEY RESULTS.—Section 1919(c) of such Act is amended by adding at the end the following new paragraph:

" '(7) POSTING OF SURVEY RESULTS.—A nursing facility must post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility conducted under subsection (g).'.".

(C) Section 1902(a)(33)(B) of the Social Security Act, as amended by section 4212(d)(3) of OBRA, is amended by striking "1919(d)" and inserting "1919(g)". 42 USC 1396a.

(D) Section 4212(e)(1)(B) of OBRA is amended by inserting "provided" after "services" each place it appears. 42 USC 1396a.

(E) Section 4212(e) of OBRA is amended by adding at the end the following new paragraph:

"(5) Section 1922(e) of such Act, as redesignated and transferred by section 4211(a)(2) of this Act, is amended by striking '1910(c)' in paragraphs (1) and (2)(A) and inserting '1910(b)'.". 42 USC 1396r-3.

(7) SECTIONS 4203 AND 4213.—(A) Sections 1819(h)(2)(B)(ii) and 1919(h)(3)(C)(ii) of the Social Security Act, as added by sections 4203(a)(2) and 4213(a) of OBRA, respectively, are each amended by striking "and the Secretary" and all that follows through "1128A." and inserting the following: ". The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).". 42 USC 1395i-3, 1396r.

(B) Sections 1819(h)(6) and 1919(h)(9) of the Social Security Act, as added by sections 4203(a)(2) and 4213(a) of OBRA, respectively, are each amended by inserting "by such facilities" after "shall be made available".

(8) SECTION 4213.—(A) Section 4213(a) of OBRA is amended by striking "as inserted by section 4201 and amended by section 4202" and inserting "as inserted by section 4211 and amended by section 4212". 42 USC 1396r.

(B) Section 1919(h) of the Social Security Act, as added by section 4213(a) of OBRA, is amended—

(i) in the last sentence of paragraph (1), by striking "(2)(A)(i)" and inserting "(2)(A)(ii)",

(ii) in the second sentence of paragraph (2)(B)(i), by striking "or otherwise", and

(iii) in paragraph (5), by striking "State and the Secretary" and inserting "State or the Secretary, respectively".

(C) Paragraph (1) of section 4213(b) of OBRA is amended by striking "1902" and all that follows through the end and inserting the following: "1902(i) of such Act (42 U.S.C. 1396a(i)) is amended— 42 USC 1396a.

"(A) in paragraph (1), by striking 'skilled nursing facility or intermediate care facility' and inserting 'intermediate care facility for the mentally retarded';

"(B) in paragraph (1), by striking 'the provisions of section 1861(j) or section 1905(c), respectively,' and inserting 'the requirements for such a facility under this title'; and

"(C) in paragraphs (2) and (3), by striking 'the provisions of section 1861(j) or section 1905(c) (as the case may be)' and inserting 'the requirements for such a facility under this title'.".

(9) SECTION 4204.—(A) Section 4204(a) of OBRA is amended by striking "extended care". 42 USC 1395i-3 note.

(B) Section 4204 of OBRA is amended—

(i) in subsection (a), by striking "made by this part" and inserting "made by sections 4201 and 4202 (relating to skilled nursing facility requirements and survey and certification requirements)",

(ii) by redesignating subsection (c) as subsection (d), and

(iii) by inserting after subsection (a) the following new subsection:

"(b) ENFORCEMENT.—(1) Except as otherwise specifically provided in section 1819 of the Social Security Act, the amendments made by section 4203 of this Act apply January 1, 1988, without regard to whether regulations to implement such amendments are promulgated by such date. Effective date.

"(2) In applying the amendments made by section 4203 of this Act for services furnished by a skilled nursing facility before October 1, 1990, any reference to a requirement of subsection (b), (c), or (d), of

section 1819 of the Social Security Act is deemed a reference to the provisions of section 1861(j) of such Act.".

42 USC 1396r note.

(10) SECTION 4214.—Section 4214 of OBRA is amended—

(A) by striking "(c) TRANSITIONAL RULE.—" and inserting "(2)",

(B) by inserting "of section 1919 of the Social Security Act" after "(b), (c), or (d)", and

(C) by redesignating subsection (d) as subsection (c).

(m) CORRECTIONS TO SUBTITLE E OF TITLE IV (RELATING TO RURAL HEALTH).—

(1) SECTION 4401.—Section 711(b)(1) of the Social Security Act, as added by section 4401 of OBRA, is amended by striking "section 4083 of the Omnibus Budget Reconciliation Act of 1987" and inserting "section 4403 of the Omnibus Budget Reconciliation Act of 1987 (as such section pertains to rural health issues)".

Rural areas. 42 USC 912.

42 USC 1395b-1 note.

(2) SECTION 4403.—(A) Section 4403 of OBRA is amended—

(i) in the heading, by striking "EXPERIMENTS AND DEMONSTRATION PROJECTS RELATING TO RURAL HEALTH CARE ISSUES" and inserting "RESEARCH AND DEMONSTRATION PROJECTS ON RURAL AND INNER-CITY HEALTH ISSUES";

(ii) in subsection (a)—

(I) by striking "SET ASIDE.—" and inserting "SET ASIDES FOR ISSUES OF HEALTH CARE IN RURAL AREAS AND IN INNER-CITY AREAS.—(1)",

(II) by striking "expended in each fiscal year" and all that follows through "1972" and inserting "annually appropriated to, and expended by, the Health Care Financing Administration for the conduct of research and demonstration projects in fiscal years 1988, 1989, and 1990",

(III) by striking "experiments" and inserting "research";

(iii) by adding at the end the following new paragraph:

Research and development. Urban areas.

"(2) Not less than ten percent of the total amounts annually appropriated to, and expended by, the Health Care Financing Administration for the conduct of research and demonstration projects in fiscal years 1988, 1989, and 1990 shall be expended for research and demonstration projects relating exclusively or substantially to issues of providing health care in inner-city areas, including (but not limited to) the impact of the payment methodology under section 1886(d) of the Social Security Act on the financial viability of inner-city hospitals and the impact of medicare policies on access to (and the quality of) health care in inner-city areas."; and

(iv) in subsection (b)—

(I) by striking "of experiments" and inserting "of research",

(II) by inserting "or to inner-city health issues" after "rural health issues", and

(III) by striking "experiments and".

(B) The item in the table of contents of OBRA relating to section 4403 is amended to read as follows:

"Sec. 4403. Set aside for research and demonstration projects on rural and inner-city health issues.".

(n) CORRECTIONS TO CERTAIN HEALTH-RELATED PROVISIONS IN TITLE IX.—

(1) SECTION 9010.—The last sentence of section 226(b) of the Social Security Act, as added by section 9010(e)(3) of OBRA, is amended to read as follows: "In determining when an individual's entitlement or status terminates for purposes of the preceding sentence, the term '36 months' in the second sentence of section 223(a)(1), in section 202(d)(1)(G)(i), in the last sentence of section 202(e)(1), and in the last sentence of section 202(f)(1) shall be applied as though it read '15 months'.". 42 USC 426.

(2) SECTION 9115.—Section 9115(b) of OBRA is amended by striking "1902(l)" and inserting "1902(o)". 42 USC 1396a.

(3) SECTION 9119.—Section 9119 of OBRA is amended by adding at the end the following new subsection:

"(d) CONFORMING AMENDMENTS TO MEDICAID PROGRAM FOR THE MEDICALLY NEEDY.—(1) Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

"(A) in subsection (a)—

"(i) by striking 'and' at the end of paragraph (48),

"(ii) by striking the period at the end of paragraph (49) and inserting '; and', and

"(iii) by inserting after paragraph (49) the following new paragraph:

" '(50) provide, in accordance with subsection (q), for a monthly personal needs allowance for certain institutionalized individuals and couples.'; and

"(B) by adding at the end the following new subsection:

" '(q)(1)(A) In order to meet the requirement of subsection (a)(50), the State plan must provide that, in the case of an institutionalized individual or couple described in subparagraph (B), in determining the amount of the individual's or couple's income to be applied monthly to payment for the cost of care in an institution, there shall be deducted from the monthly income (in addition to other allowances otherwise provided under the State plan) a monthly personal needs allowance— State and local governments.

" '(i) which is reasonable in amount for clothing and other personal needs of the individual (or couple) while in an institution, and

" '(ii) which is not less (and may be greater) than the minimum monthly personal needs allowance described in paragraph (2).

" '(B) In this subsection, the term "institutionalized individual or couple" means an individual or married couple—

" '(i) who is an inpatient (or who are inpatients) in a medical institution or nursing facility for which payments are made under this title throughout a month, and

" '(ii) who is or are determined to be eligible for medical assistance under the State plan.

" '(2) The minimum monthly personal needs allowance described in this paragraph is $30 for an institutionalized individual and $60 for an institutionalized couple (if both are aged, blind, or disabled, and their incomes are considered available to each other in determining eligibility).'. Blind persons. Handicapped persons.

"(2) The amendments made by paragraph (1) apply to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1988, without regard to whether or not Effective date. 42 USC 1396a note.

final regulations to carry out such amendments have been promulgated by such date.".

(o) SUBTITLE D OF TITLE IV.—

(1) SECTION 4303.—Section 2115 of the Public Health Service Act is amended—

42 USC 300aa-15.

(A) in subsection (i)(1), as added by section 4303(a) of OBRA, by striking "from appropriations under subsection (i)" and inserting "by the Secretary from appropriations under subsection (j)", and

(B) in subsection (j), as added by section 4303(b) of OBRA, by inserting "to the Department of Health and Human Services" after "to be appropriated".

42 USC 300aa-12.

(2) SECTION 4307.—Section 4307(3)(C) of OBRA is amended by striking "subsection (g)" and inserting "subsection (e), as redesignated by section 4303(d)(2)(A),".

(3) SECTION 4308.—(A) Subtitle D of title IV of OBRA is amended by adding at the end the following new section:

"SEC. 4308. TECHNICAL AMENDMENTS RELATING TO COURT OF CLAIMS PROCEDURES.

"(a) DUTIES OF SPECIAL MASTERS.—Section 2112(c)(2) of the Public Health Service Act (42 U.S.C. 300aa-12(a)) is amended—

"(1) by inserting ', shall prepare and submit to the court proposed findings of fact and conclusions of law,' after 'adjunct to the court',

"(2) by inserting 'and' at the end of subparagraph (C),

"(3) by striking ', and' at the end of subparagraph (D) and inserting a period, and

"(4) by striking subparagraph (E).

"(b) REQUIRING FILING OF APPEALS WITHIN 60 DAYS.—Section 2112(e) of such Act (42 U.S.C. 300aa-12(e)), as redesignated by section 4303(d)(2)(A), is amended by inserting 'within 60 days of the date of the judgment' after 'petition filed'.

"(c) CLARIFICATION ON TIMING OF BRINGING ADDITIONAL ACTIONS.—The second sentence of section 2121(a) of such Act (42 U.S.C. 300aa-21(a)) is amended by striking 'the entry of the court's judgment' and inserting 'the court's final judgment'.".

(B) The table of contents relating to title IV of OBRA is amended by inserting after the item relating to section 4307 the following new item:

"Sec. 4308. Technical amendments relating to Court of Claims procedures.".

Subtitle C—Miscellaneous Provisions

Employment and unemployment. 42 USC 1395b note.

SEC. 421. MAINTENANCE OF EFFORT.

(a) IN GENERAL.—

(1) DUPLICATIVE PART A BENEFITS.—If an employer described in subsection (b)(1) provides, as of the date of the enactment of this Act, health care benefits to an employee or retired former employee that are duplicative part A benefits (as defined in paragraph (3)(A)), the employer shall, during the period described in subsection (c)(1), provide to the employee or retired former employee an amount of additional benefits or refunds, or combination of such benefits and refunds, that total at least the

actuarial value of the duplicative part A benefits during the period described in subsection (c)(1)(A).

(2) DUPLICATIVE PART B BENEFITS.—If an employer described in subsection (b)(2) provides, as of the date of the enactment of this Act, health care benefits to an employee or retired former employee that are duplicative part B benefits (as defined in paragraph (3)(B)), the employer shall, during the period described in subsection (c)(2), provide to the employee or retired former employee an amount of additional benefits or refunds, or combination of such benefits and refunds, that total at least the actuarial value of the duplicative part B benefits during the period described in subsection (c)(1)(B).

(3) DUPLICATIVE BENEFITS DEFINED.—In this section:

(A) The term "duplicative part A benefits" means benefits which are duplicative of benefits under part A of title XVIII of the Social Security Act (as amended by this Act as of January 1, 1989), but which were not duplicative of such benefits as such part was in effect before the date of the enactment of this Act.

(B) The term "duplicative part B benefits" means benefits which are duplicative of benefits under part B of title XVIII of the Social Security Act (as amended by this Act as of January 1, 1990, but excluding any such benefits with respect to covered outpatient drugs), but which were not duplicative of such benefits as such part was in effect before the date of the enactment of this Act.

(C) Duplicative part A benefits and duplicative part B benefits shall be determined under this section net of any premiums payable by employees (or retired former employees) attributable to the respective duplicative benefits.

(b) EMPLOYERS COVERED.—

(1) DUPLICATIVE PART A BENEFITS.—An employer is described in this paragraph if the employer (including a public employer, other than an employer to which section 422 applies) provides, as of the date of the enactment of this Act, duplicative part A benefits the actuarial value of which is at least 50 percent of the national average actuarial value (discounted to the value as of the date of the enactment of this Act) of the duplicative part A benefits.

(2) DUPLICATIVE PART B BENEFITS.—An employer is described in this paragraph if the employer (including a public employer, other than an employer to which section 422 applies) provides, as of the date of the enactment of this Act, duplicative part B benefits the actuarial value of which is at least 50 percent of the national average actuarial value (discounted to the value as of the date of the enactment of this Act) of the duplicative part B benefits.

(3) ELECTION.—For purposes of this section—

(A) IN GENERAL.—An employer may elect to compute the actuarial value of duplicative part A benefits and duplicative part B benefits either—

(i) on the basis of average actuarial values published by the Secretary under subparagraph (B)(i), or

(ii) on the basis of the actuarial value with respect to that employer, computed using guidelines published by the Secretary under subparagraph (B)(ii).

(B) COMPUTATION OF ACTUARIAL VALUES.—The Secretary of Health and Human Services, before the beginning of each of 4 years (beginning with 1989 for duplicative part A benefits and beginning with 1990 for duplicative part B benefits) shall—

(i) calculate and publish the national average actuarial value of duplicative part A benefits and duplicative part B benefits for 1988 and the year involved, and

(ii) guidelines for employers to use, under subparagraph (A)(ii), in computing the actuarial value of such duplicative benefits with respect to each employer for such years.

The guidelines published under clause (ii) shall include instructions to assist employers in determining whether or not employers are described in paragraph (1) or (2) of this subsection.

(c) EFFECTIVE PERIOD.—

(1) IN GENERAL.—

(A) DUPLICATIVE PART A BENEFITS.—Subsection (a)(1) shall only be effective during the period beginning on January 1, 1989, and ending on December 31, 1989, or, if later, the date specified in paragraph (2).

(B) DUPLICATIVE PART B BENEFITS.—Subsection (a)(2) shall only be effective during the period beginning on January 1, 1990, and ending on December 31, 1990, or, if later, the date specified in paragraph (2).

(2) EXTENSION TO COVER CURRENT COLLECTIVE BARGAINING AGREEMENTS.—In the case of employees or retired former employees who are provided duplicative part A benefits or duplicative part B benefits under a collective bargaining agreement that is in effect on the date of enactment of this Act, the date specified in this paragraph is the date of the expiration of the agreement (determined without regard to any extension thereof agreed to after the date of the enactment of this Act).

(d) EXCLUSION OF MULTI-EMPLOYER PLANS.—This section shall not apply with respect to duplicative benefits provided under a plan—

(1) to which more than one employer is required to contribute, and

Contracts.

(2) which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer.

5 USC 8902 note.

SEC. 422. RATE REDUCTION FOR MEDICARE ELIGIBLE FEDERAL ANNUITANTS.

(a) IN GENERAL.—

(1) The Office of Personnel Management shall, in consultation with carriers offering health benefits plans contracted pursuant to section 8902 of title 5, United States Code, reduce the rates charged medicare eligible individuals participating in such health benefit plans, by the amount, prorated for each covered medicare eligible individual, of the estimated cost of medical services and supplies which, but for the amendments made by subtitle A of title I and subtitle A of title II of this Act, would have been payable by such plans.

Effective dates.

(2) The reduced rates as provided under paragraph (1), shall apply as of the effective dates of the respective amendments.

(b) AUTHORIZATION OF AVAILABILITY OF EMPLOYEE HEALTH BENEFITS FUND FOR RATE REDUCTION.—Funds in the Employees Health Benefits Fund established under section 8909 of title 5, United States Code, are available without fiscal year limitation for costs incurred by the Office of Personnel Management in making rate reductions provided under this section.

(c) DEFINITION.—For purposes of this section the term "medicare eligible individual" means any annuitant, survivor of an annuitant, or former spouse of an annuitant—

(1) who is—

(A) otherwise eligible for benefits under chapter 89 of title 5, United States Code;

(B) eligible for benefits under part A of title XVIII of the Social Security Act; and

(C) covered by the insurance program established under part B of such title; and

(2) for whom benefits paid under title XVIII of the Social Security Act are the primary source of health care benefits.

SEC. 423. STUDY AND REPORTS BY THE OFFICE OF PERSONNEL MANAGEMENT ON OFFERING MEDICARE SUPPLEMENTAL PLANS TO FEDERAL MEDICARE ELIGIBLE INDIVIDUALS, AND OTHER CHANGES.

(a) STUDY AND REPORT.—

(1) No later than April 1, 1989, the Director of the Office of Personnel Management shall conduct a study and submit a report to the Committee on Governmental Affairs of the Senate and the Committee on Post Office and Civil Service of the House of Representatives regarding changes to the health benefits program established under chapter 89 of title 5, United States Code, that may be required to incorporate plans designed specifically for medicare eligible individuals and to improve the efficiency and effectiveness of the program.

(2) Any medicare supplemental plan recommended by the Director of the Office of Personnel Management shall not duplicate benefits for which payment may be made under title XVIII of the Social Security Act, however such recommendation—

(A) shall cover expenses which are not payable under such title by reason of deductibles or coinsurance amounts; and

(B) may offer additional reimbursement—

(i) where benefits under such title are limited by fee schedule; and

(ii) for benefits not covered under such title which may be of value to medicare eligible individuals.

(b) FEASIBILITY STUDY AND REPORT.—No later than April 1, 1989, the Director of the Office of Personnel Management shall report to the appropriate committees of the Congress whether it is feasible to adopt such standards as issued by the National Association of Insurance Commissioners as required by section 1882 of the Social Security Act (42 U.S.C. 1395ss) for medicare supplemental policies, when providing medicare supplemental plans as a type of health benefits plan available for Federal employees pursuant to chapter 89 of title 5, United States Code.

Voluntarism.
42 USC 1395b-2 note.

SEC. 424. BENEFITS COUNSELING AND ASSISTANCE DEMONSTRATION PROJECT FOR CERTAIN MEDICARE AND MEDICAID BENEFICIARIES.

(a) TRAINING AND TECHNICAL ASSISTANCE.—

Contracts.

(1) The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish a demonstration project through an agreement with a private or public nonprofit agency or organization, which demonstrates, to the satisfaction of the Secretary, that its volunteers are adequately trained and competent to render effective benefits counseling and assistance to the elderly, for the purpose of providing training and technical assistance to prepare volunteers to provide to elderly individuals receiving benefits under title XVIII or XIX of the Social Security Act counseling with respect to eligibility for such benefits and assistance in preparing such documentation as may be required to fully receive such benefits.

(2) In addition to any other forms of technical assistance provided under this subsection, the Secretary is authorized to provide to the project—

(A) material to be used in making elderly persons aware of the availability of assistance under volunteer assistance programs under this section; and

(B) technical materials and publications to be used by such volunteers.

(b) POWERS OF THE SECRETARY.—Under the demonstration project under this section, the Secretary is authorized—

(1) to provide for the training of volunteers, and assist in such training, to insure that volunteers are qualified to provide benefits and counseling assistance (as described in paragraph (1)) to the elderly;

(2) to provide reimbursement to volunteers through the agency or organization for transportation, meals, and other expenses incurred by them in training or providing benefits counseling and assistance under this section, and such other support and assistance as the Secretary determines to be appropriate in carrying out the provisions of this section; and

(3) to provide for the use of services, personnel, and facilities of Federal executive agencies and of State and local public agencies with their consent, with or without reimbursement therefor.

(c) EMPLOYMENT OF VOLUNTEERS.—

(1) Service as a volunteer in the demonstration project carried out under this section shall not be considered service as an employee of the United States. Volunteers under the project shall not be considered Federal employees and shall not be subject to the provisions of law relating to Federal employment, except that the provisions of section 1905 of title 18, United States Code, shall apply to volunteers as if they were employees of the United States.

Taxes.

(2) Amounts received by volunteers serving in any program carried out under this section as reimbursement for expenses are exempt from taxation under chapters 1 and 21 of the Internal Revenue Code of 1986.

(d) DEFINITION.—For purposes of this section, the term "elderly individual" means an individual who has attained the age of 60 years.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, in appropriate parts from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, for fiscal years 1989, 1990, and 1991 such sums as may be necessary to carry out the provisions of this section.

SEC. 425. CASE MANAGEMENT DEMONSTRATION PROJECTS.

Contracts.
42 USC 1395b-1 note.

(a) IN GENERAL.—Within 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish 4 demonstration projects under which an appropriate entity agrees to provide case management services to medicare beneficiaries with selected catastrophic illnesses, particularly those with high costs of health care services. At least one such demonstration project shall be conducted through an agreement with a utilization and quality control peer review organization with a contract with the Secretary under part B of title XI of the Social Security Act.

(b) PURPOSE OF PROJECTS.—It is the purpose of the demonstration projects established under this section to provide the Secretary and the Congress with the information necessary—

(1) to evaluate the appropriateness of providing case management services under the medicare program for medicare beneficiaries with high costs of medical care, and

(2) to determine the most effective approach to implementing a case management system under the program for such beneficiaries.

(c) AGREEMENT.—The agreement entered into under subsection (a) shall specify—

(1) the high cost cases with respect to which case management services will be provided under the project,

(2) the payments to be made to the entity conducting the project for carrying out the project, and

(3) such other terms and conditions as the Secretary and the entity conducting the project may agree to.

(d) WAIVERS.—The Secretary shall waive—

(1) such provisions of part B of title XI of the Social Security Act, and

(2) such provisions of title XVIII of such Act as relate to limitations or restrictions on benefits under such title,

as the Secretary determines to be appropriate for the conduct of demonstration projects under this section.

(e) DURATION.—

(1) Except as provided in paragraph (2), a demonstration project under this section shall be conducted for a 2-year period.

(2) The Secretary may terminate a demonstration project before the end of the 2-year period specified in paragraph (1) if the Secretary determines that the entity conducting the project is not in substantial compliance with the terms of the agreement entered into under subsection (a).

(f) INFORMATION AND REPORTS.—

(1) An entity with an agreement under subsection (a) shall furnish the Secretary with such information as the Secretary determines to be necessary to evaluate the results of that project.

(2)(A) The Secretary shall submit to the Congress an interim report on the projects conducted under this section based upon information that is derived from the first year of project oper-

ations and shall set forth any interim findings, recommendations, and conclusions that the Secretary determines to be appropriate.

(B) The Secretary shall submit to the Congress a final report on the demonstration projects conducted under this section based upon data derived from the projects and shall update the findings, recommendations, and conclusions set forth in the interim report submitted under paragraph (1).

(g) AUTHORIZATION TO USE CERTAIN FUNDS.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Insurance Trust Fund in such proportions as the Secretary determines to be appropriate, of not to exceed $2,000,000 in each of 2 fiscal years for administrative costs in carrying out the demonstration projects under this section. Such amounts shall be transferred without regard to amounts appropriated in advance in appropriation Acts.

SEC. 426. EXTENSIONS OF EXPIRING PROVISIONS.

42 USC 1395y note.

(a) HOSPICE WAIVER OF LIABILITY PROVISION.—Section 9305(f)(2) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking "November 1, 1988" and inserting "November 1, 1990".

42 USC 1395y note.

(b) SKILLED NURSING FACILITY WAIVER OF LIABILITY PRESUMPTION.—The second sentence of section 9126(c) of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended—

(1) by striking "30-month", and

(2) by inserting before the period at the end the following: "and ending on October 31, 1990".

42 USC 1395pp note.

(c) HOME HEALTH SERVICES WAIVER OF LIABILITY PRESUMPTION.—Section 9305(g)(3) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking "October 1, 1989" and inserting "November 1, 1990".

42 USC 1395y note.

(d) HOME HEALTH WAIVER OF LIABILITY PRESUMPTION.—The second sentence of section 9205 of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking all that follows "until" and inserting "November 1, 1990.".

42 USC 1395ww note.

(e) PROHIBITION ON NEW COST-SAVING REGULATIONS.—Section 4039(d) of the Omnibus Budget Reconciliation Act of 1987 is amended—

(1) by striking "October 15, 1988" and inserting "October 15, 1989", and

(2) by inserting "or in fiscal year 1990" after "in fiscal year 1989".

42 USC 1395h note.

SEC. 427. ADVISORY COMMITTEE ON MEDICARE HOME HEALTH CLAIMS.

(a) ESTABLISHMENT.—The Administrator of the Health Care Financing Administration (in this section referred to as the "Administrator") shall, within 90 days after the date of the enactment of this Act, establish an advisory committee to be known as the Advisory Committee on Medicare Home Health Claims (in this section referred to as the "Advisory Committee").

(b) MEMBERSHIP.—The Advisory Committee shall be composed of 11 members appointed by the Administrator for the life of the Committee. Of the members appointed—

(1) at least 5 shall be representatives of home health or visiting nurse agencies, and

(2) the remaining members shall be representative of fiscal intermediaries, physician groups, and senior citizen groups, but

no more than 3 of such members may be representative of fiscal intermediaries.

Members shall be appointed so as to be representative of all geographic areas of the United States.

(c) DUTIES.—The Advisory Committee shall study the reasons for the increase in the denial of claims for home health services during 1986 and 1987, the ramifications of such increase, and the need to reform the process involved in such denials.

(d) REPORT.—The Advisory Committee shall report to the Administrator, the Committees on Ways and Means and Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate, not later than one year after the date of the enactment of this Act, on its study under subsection (c), the findings of its study, and its recommendations for changes in the regulations under title XVIII of the Social Security Act as they relate to denial of claims for home health services.

(e) MISCELLANEOUS PROVISIONS.—

(1) The Advisory Committee shall elect one of its members to serve as Chairman.

(2)(A) A majority of the members of the Advisory Committee shall constitute a quorum for the transaction of business.

(B) The Advisory Committee shall meet at the call of the Chairman, or at the call of a majority of its members.

(3) Members of the Advisory Committee shall serve without compensation, but shall be entitled to reimbusement for travel, subsistence, and other necessary expenses incurred in the performance of their duties as members of the Committee.

(4) The Advisory Committee may appoint and fix the compensation of such personnel as it deems advisable, in accordance with the provisions of title 5, United States Code, governing appointments to the competitive service, and the provisions of chapter 51 and subchapter III of chapter 53 of such title, relating to classification and General Schedule pay rates.

(5) In carrying out its duties, the Advisory Committee is authorized to hold such hearings, sit and act at such times and places, and take such testimony, with respect to matters for which is has a responsibility under this section, as the Committee may deem advisable.

(6) The Advisory Committee may secure directly from any department or agency of the United States such data and information as may be necessary to carry out its responsibilities. Upon request of the Committee, any such department or agency shall furnish any such data or information.

(7) The General Services Administration shall provide to the Commission, on a reimbursable basis, such administrative support services as the Advisory Committee may request.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 428. PROHIBITION OF MISUSE OF SYMBOLS, EMBLEMS, OR NAMES IN REFERENCE TO SOCIAL SECURITY OR MEDICARE.

(a) IN GENERAL.—Part A of title XI is amended by adding at the end the following new section:

"PROHIBITION OF MISUSE OF SYMBOLS, EMBLEMS, OR NAMES IN REFERENCE TO SOCIAL SECURITY OR MEDICARE

Law enforcement and crime.
42 USC 1320b–10.

"SEC. 1140. (a) No person may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet, or other communication, or a play, motion picture, broadcast, telecast, or other production, alone or with other words, letters, symbols, or emblems—

"(1) the words 'Social Security', 'Social Security Account', 'Social Security System', 'Social Security Administration', 'Medicare', 'Health Care Financing Administration', the letters 'SSA' or 'HCFA', or any other combination or variation of such words or letters, or

"(2) a symbol or emblem of the Social Security Administration (including the design of, or a reasonable facsimile of the design of, the social security card issued pursuant to section 205(c)(2)(E), the check used for payment of benefits under title II, or envelopes or other stationery used by the Social Security Administration) or of the Health Care Financing Administration, or any other combination or variation of such symbols or emblems,

in a manner which such person knows or should know would convey the false impression that such item is approved, endorsed, or authorized by the Social Security Administration, the Health Care Financing Administration, or the Department of Health and Human Services or that such person has some connection with, or authorization from, the Social Security Administration, the Health Care Financing Administration, or the Department of Health and Human Services.

"(b)(1) Subject to paragraph (2), the Secretary may, pursuant to regulations, impose a civil money penalty not to exceed—

"(A) except as provided in subparagraph (B), $5,000, or

"(B) in the case of a violation consisting of a broadcast or telecast, $25,000,

against any person for each violation by such person of subsection (a).

"(2) The total amount of penalties which may be imposed under paragraph (1) with respect to multiple violations in any one year period consisting of substantially identical communications or productions shall not exceed $100,000.

"(c)(1) Subsections (c), (d), (e), (g), (j), and (k) of section 1128A shall apply with respect to violations under subsection (a) and penalties imposed under subsection (b) in the same manner and to the same extent as such subsections apply with respect to claims in violation of section 1128A and penalties imposed under section 1128A(a).

Claims.

"(2) Penalties imposed against a person under subsection (b) may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in the district court of the United States for the district in which the violation occurred or where the person resides, has its principal office, or may be found, as determined by the Secretary. Amounts recovered under this section shall be paid to the Secretary and shall be deposited as miscellaneous receipts of the Treasury of the United States. The amount of such penalty when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States to the person against whom the penalty has been imposed.".

(b) AUTHORIZING CIVIL MONEY PENALTIES FOR CERTAIN VIOLATIONS RELATING TO MEDICAL SUPPLEMENTAL POLICIES.—Section 1882(d) (42 U.S.C. 1395ss(d)) is amended—

(1) by striking "shall be guilty" and all that follows through "or both" in each of paragraphs (1), (2), (3)(A), and (4)(A), and inserting in each case the following: "shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act", and

(2) by adding at the end the following new paragraph:

"(5) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under paragraphs (1), (2), (3)(A), and (4)(A) in the same manner as such provisions apply to penalties and proceedings under section 1128A(a).".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply only with respect to violations occurring on or after such date. 42 USC 1320b-10 note.

SEC. 429. DEMONSTRATION PROJECTS WITH RESPECT TO CHRONIC VENTILATOR-DEPENDENT UNITS IN HOSPITALS. 42 USC 1395b-1 note.

(a) IN GENERAL.—The Secretary of Health and Human Services shall provide for up to 5 demonstration projects, for up to 3 years each, to review the appropriateness of classifying chronic ventilator-dependent units in hospitals as rehabilitation units. Such projects shall be conducted in consultation with the Prospective Payment Assessment Commission.

(b) WAIVER AUTHORITY.—In conducting demonstration projects under this section for units, the Secretary may treat such a unit as a rehabilitation unit described in section 1886(d)(1)(B) of the Social Security Act for purposes of such section.

Approved July 1, 1988.

LEGISLATIVE HISTORY—H.R. 2470 (S. 1127):

HOUSE REPORTS: No. 100-105, Pt. 1 (Comm. on Ways and Means) and Pt. 2 (Comm. on Energy and Commerce), and No. 100-661 (Comm. of Conference).
SENATE REPORTS: No. 100-126 accompanying S. 1127 (Comm. on Finance).
CONGRESSIONAL RECORD:
Vol. 133 (1987): July 22, considered and passed House.
Oct. 9, 13, 23, S. 1127 considered in Senate.
Oct. 27, H.R. 2470 considered and passed Senate, amended, in lieu of S. 1127.
Vol. 134 (1988): June 2, House agreed to conference report.
June 8, Senate agreed to conference report.
WEEKLY COMPILATION OF PRESIDENTIAL DOCUMENTS, Vol. 24 (1988):
July 1, Presidential statement.

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100TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPT. 100–105
Part 1

MEDICARE CATASTROPHIC PROTECTION ACT OF 1987

MAY 22, 1987.—Ordered to be printed

Mr. ROSTENKOWSKI, from the Committee on Ways and Means, submitted the following

REPORT

together with

ADDITIONAL AND DISSENTING VIEWS

[To accompany H.R. 2470 which on May 19, 1987, was referred jointly to the Committee on Energy and Commerce, and the Committee on Ways and Means]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 2470) to amend title XVIII of the Social Security Act to provide protection against catastrophic medical expenses under the medicare program, and for other purposes, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

CONTENTS

	Page
I. Introduction	2
Purpose	2
Short summary	3
Background and Need for Legislation	8
II. Explanation and Justification	9
Provisions Relating to Part A	9
Inpatient Hospital Services (Sec. 101)	9
Extended Care Services (Sec. 102)	13
Hospice Care (Sec. 103)	14
Blood Deductible (Sec. 104)	15
Home Health Benefits (Sec. 105)	15
Supplemental Premium (Sec. 106)	16
Provisions Relating to Part B	21
Limitation on Medicare Out-of-Pocket Expenses Under Part B (Sec. 201)	21
Extending Home Health Services (Sec. 202)	23

Increase In Maximum Payment Allowed for Outpatient Mental Health Benefits (Sec. 203) 24
Mailing of Notice of Medicare Benefits and Participating Physician Directories (Sec. 204) 25
Providing Additional Medical Assistance for Indigent Medicare Beneficiaries (Sec. 205) 26
Adjustment in Medicare Part B Premium (Sec. 206) 27
Changes in Certification of Medicare Supplemental Health Insurance Policies (Sec. 207) 30
Extension of Social HMO Demonstration Projects (Sec. 208) 32
Study on Comprehensive Medical Coverage Under the Medicare Program (Sec. 209) 32
Research on Long-Term Care for Medicare Beneficiaries (Sec. 210) 33
III. Budget Effects of the Bill 34
Committee Estimate 34
Statement Regarding New Budget Authority and Tax Expenditures 35
Cost Estimate Prepared by the Congressional Budget Office 35
IV. Other Matters Required to be Discussed Under House Rules 44
Vote of the Committee 44
Oversight Findings 44
Oversight by Committee on Government Operations 44
Inflation Impact 44
V. Changes in Existing Law Made by the Bill, as Reported 44
VI. Additional Views 73
VII. Dissenting Views 77
VIII. Additional Dissenting Views 82

I. Introduction

PURPOSE

The Committee bill, H.R. 2470, the Medicare Catastrophic Protection Act of 1987, would provide acute care catastrophic protection for hospital and physician services and improve coverage under the Medicare program in several ways. This bill would protect Medicare beneficiaries from catastrophic hospital expenses by limiting beneficiary liability to one hospital deductible in a calendar year. It would limit beneficiary expenses for stays in a skilled nursing facility to seven days of coinsurance in a calendar year. Hospice reimbursement would be extended beyond the current 210 day limit to assure that terminally ill Medicare beneficiaries would have access to the hospice benefit.

The bill would also limit Medicare beneficiary liability for covered Part B services. This limit would be approximately $1,043 in 1988 and increase in subsequent years by the same percentage increase as provided for Social Security benefits. The bill would also improve the Medicare benefit with regard to home health and outpatient mental health services. Another provision of the bill would require states to pay the Medicare premium, deductible and coinsurance amounts for all elderly and disabled with incomes up to the Federal Census Bureau poverty threshold. Changes concerning the Federal standards and requirements for Medicare Supplemental Insurance (medigap) policies are also included in the bill in order to protect Medicare beneficiaries who purchase these policies.

Lastly, the bill provides for financing of these benefits in a budget neutral manner. Medicare beneficiaries who file a Federal income tax return would pay a supplemental premium based on their adjusted gross income beginning in 1988. Further, in 1990 and 1991 a small additional premium amount would be added to Medi-

care beneficiaries' current Part B premium. Medicare beneficiaries in American Commonwealths and Territories would also pay an additional premium beyond the current law Medicare Part B premium, as would individuals who are not eligible for Part A of Medicare but purchase Part B of Medicare.

SHORT SUMMARY

Provisions relating to part A

I. Inpatient hospital services

a. Inpatient hospital deductible.—The inpatient hospital deductible would apply only to a beneficiary's first period of continuous hospitalization beginning in a period of continuous hospitalization beginning in a calendar year. The deductible would be indexed to the Social Security cost-of-living adjustment (COLA) each year. This deductible is estimated to be approximately $541 in 1988.

b. Elimination of day limitation on inpatient hospital services.—The Medicare limits on payment for days of inpatient hospital care (90 days of inpatient hospital care plus a lifetime reserve of 60 days) would be eliminated so that Medicare would pay for an unlimited number of hospital days for covered services. The 190-day lifetime limit on inpatient psychiatric hospital services would be retained.

c. Elimination of coinsurance amounts for inpatient hospital services.—The current hospital inpatient coinsurance amounts for days 61 through 90 and coinsurance for the 60 lifetime reserve days would be eliminated.

d. Elimination of spell of illness.—The "spell of illness" methodology would be eliminated for determining: the number of hospital days Medicare would cover, the skilled nursing facility coinsurance and the Part A blood deductible.

e. Adjustments in payments for inpatient hospital services.—When adjusting the Medicare hospital payment system, the Secretary of Health and Human Services (HHS) would be required to take into account the reductions in beneficiary payments to hospitals because of the elimination of the day limitation. The Secretary, when appropriate, would adjust the payment rates under the prospective payment system (PPS), the outlier cutoff points, the weighting factors, and the target amounts for paying non-PPS hosptials.

II. Extended care services (skilled nursing facility)

a. *Coinsurance on first seven days.*—Beneficiaries would be required to pay coinsurance amounts for the first seven days of such services.

b. *Coinsurance equal to 20 percent.*—The coinsurance amount per day would be equal to 20 percent of the national average per diem Medicare reasonable cost for skilled nursing facility (SNF) services in the succeeding year. The coinsurance amount is estimated to be approximately $24 per day in 1988.

c. *Cover 150 days of care.*—The Medicare program would cover 150 days, instead of the current 100 days, of skilled nursing care services in a calendar year.

d. *Prior hospitalization requirement.*—The three-day prior hospitalization requirement for skilled nursing facility benefits would be eliminated effective for skilled nursing facility stays beginning on or after January 1, 1989.

III. Hospice care

a. *Extending day limit on hospice care.*—The Medicare program would extend the hospice benefit, and reimburse a hospice, beyond the current 210-day benefit period if the beneficiary's physician or hospice director recertified that the beneficiary was still terminally ill.

IV. Blood deductible

a. *Change blood deductible requirement.*—A Medicare beneficiary would be responsible for payment of a deductible equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells) furnished each calendar year. The blood deductible could be met by replacing the blood, in accordance with regulations.

V. Transfer of home health benefits to part B

a. *Transfer of home health benefits to Part B.*—Beginning on January 1, 1989, home health care benefits would be a covered benefit under Part B only, except for individuals eligible for Part A but not enrolled in Part B. There would be no change in coverage or reimbursement policies for these home health benefits.

VI. Financing

a. *Supplemental premium.*—A supplemental premium would be calculated from a Medicare Part A eligible individual's adjusted gross income for tax purposes. This supplemental premium would depend on income, and would be determined from a table in the tax form instructions. However, adjusted gross income would not be increased. The supplemental premium would be adjusted to reflect the increase in the cost of Medicare benefits. The supplemental premium would be mandated and not treated as a deductible medical expense. The maximum supplemental premium an individual would pay in 1988 would be approximately $580 and in 1992, approximately $930.

Individuals not required to pay the supplemental premium would include: (1) any individual who is entitled to benefits under Part A of Medicare solely by reason of the payment of a premium for Part A, (2) any individual who is required to pay an additional Part B premium by virtue of being a resident of an American Commonwealth or Territory, (3) any individual who is required to pay an additional Part B premium because the individual is entitled only to Part B benefits, and (4) any qualified nonresident.

VI. Effective date

a. *Effective date.*—The above Part A benefits would be effective for services provided on or after January 1, 1988. Tax changes would apply to taxable years ending after December 31, 1987.

Provisions relating to part B

I. Limitation on Medicare out-of-pocket expenses under part B

a. *Limit out-of-pocket expenses.*—After a Medicare beneficiary had incurred out-of-pocket Part B covered expenses in a calendar year which exceeded the Part B catastrophic limit, (a) Medicare would be required to pay 100 percent of reasonable charges (or in some cases, the reasonable costs) for any additional Part B covered services in the year, and (b) no further deductibles would be required.

Out-of-pocket Part B expenses would be defined to include the Part B $75 deductible, the Part B blood deductible, $250 of reimburseable mental health services and the 20-percent coinsurance required to be paid by beneficiaries for Part B benefits.

The Part B catastrophic limit would be $1,043 in 1989 and increased by the Social Security COLA in succeeding years.

For prepaid health care organizations paid on the basis of aggregate reasonable cost, the Secretary would be required to provide for an appropriate adjustment to their payment amounts to reflect the increase in protection as if payment were made on an individual-by-individual basis.

b. *Institutional provider limitation.*—Institutional providers with agreements with the Medicare program would be prohibited from charging Medicare beneficiaries for services for which catastrophic benefit payments are made to the provider.

II. Home health services

a. *Home health.*—The "intermittent" skilled nursing care definition for home health services would be expanded so that "daily" would be defined as up seven days a week for up to 35 days in any given period, instead of five days a week for up to two or three weeks. A subsequent extension could be provided based on a physician's certification of exceptional circumstances requiring the continuation of services beyond the 35 days.

III. Outpatient mental health services

a. *Outpatient mental health.*—The present law maximum Medicare reimbursement for mental health outpatient services would be raised from the current limit of $250 ot $1,000 per calendar year. The coinsurance requirement would remain the same.

IV. Mailing notice requirement and physician directories

a. *Mailing notice requirement and physician directories.*—The Secretary would be required to prepare an annual notice to be sent to all Medicare beneficiaries that would provide a simple, clear explanation of Medicare benefits. This notice would also include an explanation of the limits of the Medicare and Medicaid programs with regard to long term care benefits. In addition, a directory of participating physicians would be sent to each beneficiary each year starting in January, 1988.

V. Providing additional medical assistance for indigent Medicare beneficiaries

a. Providing Additional Assistance for Indigent Medicare Beneficiaries.—The Federal Supplemental Security Income program (SSI) would be amended to establish a separate category of elderly and disabled for whom state Medicaid programs, including states operating under section 1115(a) waivers, would be required to pay the Medicare premium, deductibles and coinsurance amounts.

All elderly and disabled individuals with incomes up to the Federal Census Bureau poverty threshold level would be entitled to participate in this program. The current Federal matching requirements would apply to this provision. The States would be required to begin paying monthly premiums for months beginning with July, 1988, and for items and services provided on and after July 1, 1988.

VI Part B premium adjustment

a. Part B premium adjustment.—The Part B premium would be ajdusted so that $1,00 per month would be added to the current law Part B monthly premium in 1990; and a net amount equal to approximately $1.50 per month would be added in 1991 and 1992. Thereafter, the Part B premium would be increased by the same percentage increase as the increase in the cost-of-living adjustment for Social Security benefits

b. Part B premium for residents of U.S. Commonwealths and Territories.—Medicare beneficiaries residing in the American Territories and Commonwealths would be required to pay an additional Part B premium approximately equal to the average per capita value of the new catastrophic benefits contained in this bill.

This amount would be divided by twelve, and one-twelfth would be added to the current law monthly Part B premium beneficiaries now pay. In subsequent years the monthly premium would be increased by the same percentage increase as the increase in the cost-of-living adjustment for Social Security benefits.

c. Part B premium for individuals enrolled under part B but not entitled to benefits under part A.—Medicare beneficiaries who are not entitled to Part A benefits but who voluntarily enroll in Part B would be required to pay an additional Part B premium equal to the average per capital value of the new catastrophic benefits contained in this bill.

This amount would be divided by twelve, and one-twelfth would be added to the current law monthly Part B premium beneficiaries now pay. In subsequent years the monthly premium would be increased by the same percentage increase as the increase in the cost-of-living adjustment for Social Security benefits.

VII. Medicare supplemental health insurance policies

a. Establishment of new medigap standards.—The Secretary, taking into consideration any recommendations developed by the National Association of Insurance Commissioners and the Medicare catastrophic legislation passed by the Congress, would be required to report to Congress, within 1500 days after enactment of the legislation, his recommendations for changes that would be made in

the Federal requirements for certification of Medicare supplemental policies.

b. Required mailing of notice.—Companies that issue Medicare supplemental policies that are in effect on January 1, 1988, would be required by January 31, 1988, on a one-time basis, to send a letter to their policyholders who are entitled to Medicare, explaining the improved benefits contained in the catastrophic legislation passed by the Congress and how these improvements will affect the benefits contained in the medigap policies and the cost of these premiums.

c. *Required submission of advertising.*—Companies that issue Medicare supplemental policies would be required to submit their advertising files to each State Insurance Commission, in which they do business, for review as to whether their marketing practices comply with State law with respect to advertising used on or after January 1, 1988.

d. *Transition for current policies.*—Federal penalties for noncompliance with the substantial duplication of health benefits requirement contained in section 1882(d)(3)(A) would be suspended for two years, beginning January 1, 1988, and ending December 31, 1989, for existing Medicare supplemental policies, but new policies would still be subject to the penalties and fines of not more than $25,000 or imprisonment for not more than five years, or both, after Medicare catastrophic legislation is enacted.

VIII. Extension of social HMO demonstration project

a. *Social HMO waiver.*—The current Health Care Financing Administration waiver would be extended through September, 1992, for the four Special Health Maintenance Organization demonstration projects.

IX. Study on comprehensive medical coverage under the Medicare Program

a. *Comprehensive Medicare coverage study.*—The General Accounting Office would be required to conduct a study to assess the need for, and costs of, including comprehensive medical coverage under the Medicare program, such as extended-care services, routine dental and eye examinations, and long-term care services.

X. Research on long-term care for Medicare beneficiaries

a. *Long-term care research.*—Five million dollars would be authorized for each of the next five years for the Secretary of the Department of Health and Human Services to support research on long-term care. The research would focus on issues of delivering and financing of long-term care services.

XI. Effective date

a. *Effective date.*—The effective dates for Part B benefits would be for services furnished on or after January 1, 1989. The additional premium for individuals who voluntarily enroll in Medicare would begin in January 1990. The additional premium for Medicare beneficiaries residing in the Commonwealths and Terrorities would begin in January 1988. The additional premium for those in-

dividuals not entitled to Part A benefits except by payment of a premium but who buy Part B would begin in January 1989.

BACKGROUND AND NEED FOR LEGISLATION

The Committee bill, H.R. 2470, would protect Medicare beneficiaries from catastrophic expenses associated with covered hospital and physician services. The need for this bill is evident, as Medicare, the Federal program designed to meet the acute medical care needs of older Americans does not cover truly catastrophic hospital and physician expenses.

Despite the trend toward generally improved health status of the elderly, their needs for health care remain substantial. Greater life expectancy merely postpones the inevitable need for care of chronic and terminal illnesses. Many of the elderly have one or more chronic conditions, many of which give rise to the need for continuing health care. For example, nearly half report having arthritis, forty percent report high blood pressure, and nearly one-third report heart disease. The incidence of many chronic conditions is directly related to age and inversely related to family income. A recent study found that the six percent of Medicare beneficiaries who died in 1978 accounted for twenty eight percent of Medicare expenditures, suggesting that Medicare beneficiaries in their last year of life are severely or chronically ill.

Expenditures for personal health care services for the elderly nearly tripled between 1977 and 1984, rising from $43 billion to an estimated $120 billion. Per capita spending rose an average of thirteen percent annually during those years, from $1,785 to $4,202.

Fairly extensive coverage is provided for short-term hospital stays under Medicare Part A. Coverage for long-term hospital stays is less adequate. These long stays are subject to significant coinsurance charges. Further a beneficiary may potentially exhaust all benefits and be required to pay thousands of dollars of hospital and physician charges. In addition to a monthly premium, beneficiaries enrolled in Part B are liable for certain charges in connection with their use of physicians and other charges in connection with their use of physicians and other services covered under the program. All beneficiaries are liable for the $75 deductible and the twenty percent coinsurance charges. In addition, where a physician or other provider does not accept "assignment" (i.e., agree to accept Medicare's determination of the reasonable charge amount as payment in full for covered services), the beneficiary is liable for the difference between Medicare's reasonable charge amount and the physician's actual charges.

Even though Medicare in 1987 will spend close to $80 billion on medicare care, the elderly will also have out-of-pocket expenses of over $30 billion, not including long-term care. Out-of-pocket expenses by the elderly represent the difference between total health expenditures by the elderly and known third party payments. These out-of-pocket payments include Medicare copayments (less any benefits paid by so-called "Medigap" plans), collected reasonable charge reductions, net private health insurance copayments, and the purchase of care not covered by any third party. It is important to note that direct out-of-pocket payments to providers are

not the only expenditures by the aged for health care. The aged also pay Medicare Supplementary Medical Insurance (Part B) and private health insurance premiums that are not defined as out-of-pocket expenditures. Private health insurance, including Medigap policies, covers an additional estimated seven percent ($304 per capita) of personal health expenditures for the elderly.

About eight million senior citizens will spend some time in the hospital this year. For those with one inpatient stay the average out-of-pocket liability will run about $1,335, but for those with lengthy hospital stays the expenses can add up to thousands of dollars resulting in financial ruin.

For some elderly the amount of health care expenses paid out of pocket can be a greater burden than for others, depending on their income. In 1986, over twenty percent of senior citizens had to spend at least fifteen percent of their income on medicare care, while seven percent spent twenty-five percent or more of their income paying medical bills.

While Social Security payments have lifted many of the elderly out of poverty, nineteen percent or about six million, have incomes below the poverty threshold of $5,000 and forty-nine percent of older Americans still have income below $10,000. Having to spend twenty-five percent of $10,000 of income on medical expenses is truly catastrophic.

It has been argued that Medigap or private supplemental insurance policies are already meeting the catastrophic medical needs of the elderly. While seventy percent of the elderly buy Medigap insurance, many of these policies, according to a recent General Accounting Office study (GAO/HRD–87–8), are very inefficient supplements. Many return, on average, only sixty cents on the dollar in benefits. In other words, seniors paid more than a billion dollars in premiums than the policies paid out in benefits. In addition, many policies have pre-existing clauses which prevent seniors from filing claims for needed medical care. The Medicare program has only two percent administrative costs, which means it can pay out ninety-eight percent in benefits without denying benefits for those with pre-existing conditions.

Furthermore, the likelihood of a Medicare beneficiary having a supplemental insurance policy increases with income. Low-income elderly, therefore, are often without supplemental policies that could meet some of their catastrophic medical needs.

Given the rising cost of medical care, the aging of the population and the growing disparity between what Medicare will and will not pay for, it is evident that the Medicare program needs to be expended to fill the acute care gaps in coverage, which can lead to financial bankruptcy by Medicare beneficiaries.

II. Explanation and Justification

TITLE 1—PROVISIONS RELATING TO PART A OF MEDICARE

Sec. 101. Inpatient hospital services

Present law

(a) Application of inpatient hospital deductible on a calendar year basis and limitation to one deductible each year.— Under current

law beneficiaries are required to pay a first day hospital deductible for inpatient hospital services furnished in each "spell of illness" ($520 in 1987). A "spell of illness" is a period of consecutive days that begins with the first day on which a patient is furnished inpatient hospital or extended care services and ends with a period of 60 consecutive days during which the beneficiary was neither an inpatient of a hospital nor a skilled nursing facility. A beneficiary may be discharged from and readmitted to a hospital or skilled nursing facility several times during a spell of illness and still be in the same spell if 60 days have not elapsed between discharge and readmission.

(b) Elimination of general day limitation on inpatient hospital services.— Under current law a beneficiary is entitled to inpatient hospital services for up to 90 days in any one "spell of illness." In addition to the 90 days of hospital care, each beneficiary has a lifetime reserve of 60 days of added coverage after the 90 days have been exhausted. After a beneficiary has received 90 days of care in a "spell of illness" and exhausted the 60 lifetime reserve days, Medicare does not provide for further hospital reimbursement and the beneficiary is responsible for all hospital charges.

Under current law, there are separate day limitation restrictions on inpatient psychiatric hospital care. If an individual is an inpatient of a participating psychiatric hospital on the first day for which the beneficiary is entitled to hospital insurance benefits, the days on which the beneficiary was an inpatient of a psychiatric hospital in the 150-day period immediately before this first day are deducted from the 150 days of inpatient psychiatric services for which the beneficiary is otherwise entitled to have payment made during the first "spell of illness", if these services were furnished to the beneficiary in a psychiatric hospital. Further, payment may not be made for more than a total of 190 days of inpatient psychiatric hospital services during a beneficiary's lifetime.

(c) Elimination of coinsurance amounts for inpatient hospital services.—Under current law beneficiaries are required to pay coinsurance when inpatient hospital services are received for more than 60 days during a "spell of illness." The beneficiary is responsible for a coinsurance amount for each day after the 60th and through the 90th day and by law the daily coinsurance amount is equal to one-fourth of the inpatient hospital deductible ($130 a day in 1987). There is also a coinsurance amount for each day, after the 90th day and through the 150th day in any "spell of illness", that is chargeable against the individual's 60 lifetime reserve days. The coinsurance for these days by law is equal to one-half of the inpatient hospital deductible ($260 a day in 1987).

(d) Indexing of inpatient hospital deductible.—Under current law the amount of the hospital deductible is revised each January and is equal to the inpatient hospital deductible for the preceeding calendar year, updated by the same percentage that applies to prospective payment (PPS) rates and adjusted to reflect changes in real case mix.

(e) Determination of part A premium.—Under current law individuals age 65 or over who are not entitled to Hospital Insurance (Part A) benefits may voluntarily enroll in the Hospital Insurance program if they pay a monthly premium. The premium currently

does not reflect the actuarial value of the Hospital Insurance benefit. Instead, the Secretary is required to calculate the premium each year under a formula that is equal to $33 multipled by the ratio of the inpatient hospital deductible for the subsequent calendar year to the deductible promulgated for 1973.

(f) Adjusting payments for inpatient hospital services.—Under current law, hospitals in general are paid on the basis of a prospective payment system in which Medicare pays a prospective amount for each Medicare discharge based on one of the 470 different diagnosis-related groups (DRGs). The DRG payments are based on the assumption that Medicare will cover at most 90 days of covered hospital services in a "spell of illness" and 60 lifetime reserve days.

The Committee believes there is a need for acute hospital care catastrophic coverage. Either million senior citizens will spend some time in the hospital this year. For the fifteen percent of Medicare beneficiaries who will have one inpatient stay the average out-of-pocket liability will run about $1,165. For the seven percent who will have two or more stays in the hospital the average out-of-pocket cost will amount to over $2,000. For the half a percent of beneficiaries who have lengthy hospital stays requiring the payment of coinsurance amounts, the average out-of-pocket expenses will average approximately $7,600. For low and moderate income elderly such costs can deplete lifetime savings, leaving substantial debts.

In 1986, over twenty percent of senior citizens had to spend at least fifteen percent of their income on their medical care, which seven percent were forced to spend twenty five percent or more of their income paying medical bills.

The Committee also believes complex features of the program such as the "spell of illness" methodology should be eliminated. For these reasons the Subcommittee has proposed the following changes in the Medicare program to eliminate the potential for financial ruin resulting from lengthy hospital stays and to reduce the complexity of the program.

Because the hospital benefit will be extended to 365 days of hospital care from the current limit of 150 days in a calendar year, the Committee believes there is a need to give the Secretary discretion to adjust, if necessary, the DRG payments, as well as the targeted amounts, outlier cutoff points and weighting factors in determining payments to hospitals.

Explanation of provisions

(a) Application of inpatient hospital deductible on a calendar year basis and limitation to one deductible each year.—A beneficiary would be required to pay only one hospital deductible in a calendar year no matter how many times the beneficiary was admitted to a hospital during the calendar year. The "spell of illness" methodology would be eliminated for determining the number of hospital deductibles, the number of days Medicare would cover, and the hospital coinsurance amounts. A new deductible would not be required if the hospitalization began in one calendar year and continued into the following year, but a deductible would be required if the beneficiary reentered the hospital later in the second year.

(b) Elimination of general day limitation on inpatient hospital services.—The Medicare limits on payment for 150 days of inpatient hospital care would be eliminated so that Medicare would pay for an unlimited number of hospital days for covered services in a calendar year. However, the current 190 day lifetime limit and 150 day rule on inpatient psychiatric hospital services would be retained.

(c) Elimination of coinsurance amounts for hospital services.—The current requirement for the payment of hospital coinsurance amounts for inpatient days 61 through 90 and the 60 lifetime reserve days would be eliminated.

(d) Indexing of inpatient hospital deductible.—The method of determining the inpatient hospital deductible beginning in 1988 would be changed so that it would equal the preceeding year's deductible, increased by the cost-of-living adjustment to Social Security benefits. Not later than November 15 of each year, beginning in 1987, the Secretary would be required to promulgate the inpatient hospital deductible for the suceeding year.

(e) Determination of part A premium.—The Secretary would be required to establish a Part A premium for those who voluntarily enroll in Part A equal to the actuarial value of the Part A benefit. The actuarial value would equal one-twelfth of the estimated average per capita amount payable from the Hospital Insurance Trust Fund for services and related administrative costs incurred in the succeeding calendar year for individuals age 65 and over entitled to hospital benefits during that entire year. The Secretary would be required to determine and promulgate the premium during September of each year and issue a public statement setting forth the actuarial assumptions and basis employed in determining the actuarial rate.

(f) Adjustment in payments for inpatient hospital services.—When adjusting the Medicare hospital payment system, the Secretary would be required to take into account the reductions in beneficiary payments to hospitals because of the elimination of the day limitation. The Secretary, when appropriate, would adjust the payment rates under the prospective payment system (PPS), the outlier cutoff points, the weighting factors, and the target amounts for paying non-PPS hospitals.

Effective date

(a) and (d). The changes relating to the deductible would be for inpatient hospital services furnished on or after January 1, 1988, and succeeding years. However, in the case of an individual for whom a spell of illness began before January 1, 1988, and had not yet ended as of such date, the deductible would not apply to services furnished during that spell of illness during 1988 or 1989.

(b) and (c) The changes relating to the extension of benefits and coinsurance would be effective for inpatient hospital services furnished on or after January 1, 1988.

(e) The changes relating to the Part A premium would apply to premiums for months beginning with January 1, 1988.

(f) The Secretary, when appropriate, would adjust inpatient hospital payments to hospitals for services furnished on or after January 1, 1988.

Sec. 102. Extended care services

Present law

(a) Coinsurance rate of 20 percent of national average per diem for services furnished during first 7 days of each calendar year.—Under current law a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day after the 20th and before the 101st day of extended care services furnished during a "spell of illness" ($65 a day in 1987).

The Committee believes the current method of calculating the coinsurance amount has resulted in an excessive coinsurance requirement. In parts of the country the daily coinsurance amount is now greater than the cost of the day's stay in the skilled nursing facility.

(b) Extension to 150 days in each calendar year.—Under current law a beneficiary is entitled to post-hospital extended care services in a qualified skilled nursing facility for up to 100 days in any one "spell of illness."

It is the belief of the Committee that the "spell of illness" methodology for determining skilled nursing facility coinsurance is an unnecessary complexity which can become a financial barrier to a beneficiary's access to care.

(c) Eliminating hospital requirement for coverage of extended care services.—Under current law services in a skilled nursing facility are covered under Medicare only after an individual has been transferred to the facility from a hospital in which the individual was a patient for not less than three consecutive calendar days before being discharged in connection with the transfer.

The Commission believes the three day prior hospitalization rule has created a barrier to needed skilled nursing care for those who do not require hospitalization. Given that an increasing number of surgical procedures are performed on an outpatient basis, it is the Committee's belief that Medicare beneficiaries who require skilled nursing care should be entitled to such care in a skilled nursing facility when they do not need to be hospitalized and otherwise qualify for the home health benefit. The Congress has already eliminated the three day prior hospitalization rule for the home health benefit.

Explanation of provision

(a) Coinsurance rate of 20 percent of national average per diem for services furnished during first 7 days of each calendar year.—A Medicare beneficiary would be required to pay coinsurance amounts for the first 7 eays of covered services in a calendar year. The coinsurance amount for each day would equal 20 percent of the national average per diem Medicare reasonable cost for SNF services in the succeeding calendar year, as estimated by the Secretary each year. The Secretary would, in September of each year (beginning in 1987) promulgate the coinsurance amount which shall apply to post-hospital extended care services furnished in the succeeding year.

(b) Extension to 150 days in each calendar year.—The Medicare program would cover up to 150 days of post-hospital extended care services furnished during a calendar year.

(c) Eliminating hospital requirement for coverage of extended care services.—The three day prior hospitalization requirement to receive extended care services in a skilled nursing facility would be eliminated.

Effective date

(a) and (b) The coinsurance and extension of days would be effective for services furnished on or after January 1, 1988.

(c) The elimination of the three day hospital requirement would become effective for skilled nursing facility stays beginning on or after January 1, 1989.

Sec. 103. *Hospice care*

Present law

(a) Extension of coverage period—Under current law, a beneficiary who is terminally ill is entitled to elect to receive hospice care for periods of 90 days and one subsequent period of 30 days for a total of 210 of hospice care.

In keeping with efforts to cover catastrophic acute care medical costs, the Committee believes the hospice benefit should continue to be available to Medicare beneficiaries who are still terminally ill after the 210 day hospice benefit expires.

(b) Continued Certification of Terminal Illness for Extended Benefits.—Under current law in order to receive the hospice benefit the beneficiary's attending physician and the medical director (or staff physician) of the hospice program must certify, not later than two days after hospice care is initiated, that the beneficiary is terminally ill (i.e. that the beneficiary has a medical prognosis that his life expectancy is six months or less). If the beneficiary elects to receive hospice care for a second or third period, the medical director must recertify at the beginning of that period that the beneficiary is terminally ill.

Currently, some hospices are refusing to provide the hospice benefit to Medicare beneficiaries if they believe the individual will live beyond the 210 day limit because the hospice will not be reimbursed for care delivered beyond the 210 day limit.

Explanation of provision

(a) Extension of coverage period.—A Medicare beneficiary would be entitled to a subsequent extension of the hospice benefit after the 210 day limit under certain circumstances.

(b) Continued certification of terminal illness for extended benefits.—A subsequent extension period for the hospice benefit would be granted beyond the 210 day limit if the Medicare beneficiary was recertified as terminally ill by the attending physician or medical director.

Effective date

(a) and (b) The changes in the hospice benefit would be effective for hospice care furnished on or after January 1, 1988.

Sec. 104. *Blood deductible*

Present law

Under current law a beneficiary is required to pay a separate deductible equal to the cost of the first three pints of whole blood (or equivalent quantities of red blood cells) received by a beneficiary as part of the services furnished under the hospital insurance (Part A) program during each "spell of illness." There is also a separate deductible under Part B of Medicare equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of red blood cells) furnished to a beneficiary during a calendar year.

In keeping with the elimination of the "spell of illness" concept for hospital services, it is necessary to conform the blood deductible rules and eliminate the "spell of illness" concept for the blood deductible.

Explanation of provision

A Medicare beneficiary would be responsible for payment of a deductible equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells) furnished each calendar year, except that the deductible for such blood would be reduce appropriately, in accordance with regulations developed by the Secretary of Health and Human Servcies, to the extent that there had been a replacement of such blood. The Secretary is directed to utilize the same replacement requirements that are currently used for the Part B blood deductible replacement requirements.

A Medicare beneficiary would be required to pay only one blood deductible in a calendar year under Parts A or B in any calendar year.

Effective date

The changes in the blood deductible would be effective for blood or packed red blood cells furnished on or after January 1, 1988.

Sec. 105. Home health benefits

Present law

Under current law home health care is a covered benefit under both Medicare Parts A and B. Payment for home health care, however, is made from the Part A trust fund for all home health services except for those provided to individuals enrolled under Part B, but not entitled to receive benefits under Part A. Only about 1 percent of home health is reimbursed under Part B.

Eligibility and reimbursement policies are identical for home health services reimbursed under Parts A and B. There is no coinsurance or deductible payment requirement for home health either under Part A or Part B.

Under current law, the Part B premium is set at 25 percent of total Part B program costs. Beginning in 1989, the Part B premium will be set at the lower of: (1) an amount sufficient to cover one-half of the costs of the program, or (2) the current premium amount increased by the percentage by which cash benefits were

increased under the Social Security cost of living adjustment (COLA).

Traditionally, Medicare Part A has been reimbursed from the Hospital Insurance Trust Fund which is financed almost exclusively from payroll taxes. It is the belief of the Committee that in order to help maintain the solvency of the Hospital Insurance Trust Fund that the home health benefit be transferred to the Part B portion of the Medicare program.

Explanation of provision

Beginning with fiscal year 1989, home health care would no longer be a covered benefit under Medicare Part A, except for individuals eligible for benefits under Part A who have not enrolled under Part B. Individuals eligible for benefits under Part A who have not enrolled under Part B would continue to be eligible for home health benefits under Part A. Individuals enrolled under Part B would only be entitled to receive home health benefits under Part B.

There would be no change in coverage or reimbursement policies for home health services. There also would be no change in current law regarding calculation of the Part B premium: the 1989 premium would be based on the 1988 premium increased by the Social Security COLA.

Effective date

Effective for home health services furnished on and after January 1, 1989.

Sec. 106. Supplemental premium

Present law

Under current law, individuals who have attained age 65 and who are eligible for monthly social security or railroad retirement cash benefits are eligible, without additional application, to coverage under the Hospital Insurance (Part A) program of Medicare without any payment for the coverage. Eligibility for Part A coverage begins with the first day of the month in which an individual eligible for retirement benefits as a social security retirement beneficiary, qualified railroad retirement beneficiary, or "survivor" beneficiary under either program attains age 65. Entitlement ends with the earlier of the last day of the month of death or the last day of the month before the month in which the beneficiary no longer meets the requirements for entitlement to social security, railroad retirement, or survivor benefits.

Part A coverage also is available, without payment of the Part A premium, to individuals under age 65 who have been entitled for not less than 24 months to social security or railroad retirement benefits on the basis of disability. This entitlement for Part A coverage applies to qualified railroad retirement disability beneficiaries and the following categories of social security beneficiaries: disabled workers, disabled widows and widowers between the ages of 50 and 65, certain women age 50 or older entitled to mother's benefits, and individuals age 18 and over who receive social security benefits because they became disabled before reaching age 22.

Entitlement to Part A begins with the first day of the 25th month of entitlement to social security or railroad retirement benefits on the basis of disability. Such entitlement to Part A continues until the end of the month following the month in which notice of the termination of disability status is mailed to the beneficiary, or, if earlier, with the end of the month before the month in which the beneficiary attains age 65.

Further, Part A coverage is available, without payment of the Part A premium, to individuals, even though they have not reached age 65, who have end-stage renal disease (i.e., kidney impairment that appears irreversible and permanent and requires either a regular course of dialysis or kidney transplantation to maintain life). End-stage renal disease Medicare benefits are available only after an application for Medicare benefits is filed.

The bill substantially improves Medicare benefits by adding catastrophic coverage. In developing a funding mechanism for such improvements, the Committee followed four basic principles. First, the funding mechanism should cover the cost of the benefit improvements. Second, the committee believed that the cost of the benefit improvements should be borne by those receiving the improved benefits. Third, the burden of the additional cost largely should be based on the ability to pay, since there is already in place a $17.90 per month Part B premium that is scheduled to increase substantially under present law. This protects low-income beneficiaries from having to pay a substantial share of the new costs. Fourth, the committee did not want to require the filing of a tax return by any individual not otherwise required to file a return.

The Committee examined various alternatives in light of these principles and determined that an income-related supplemental premium paid by Medicare enrollees and collected through the income tax system was the fairest and most administrable method of financing the bulk of the new catastrophic benefits. In addition, because the Committee believed that a small portion of the cost of the new benefits should be borne equally by all Part B enrollees, the bill would provide that Part B enrollees would pay an additional $1 per month Part B premium beginning in 1990 and an additional $.40 per month beginning in 1991.

Under the bill, the supplemental premium would be collected only from those required to file tax returns and thus will affect less than half of all Medicare beneficiaries. Unlike the existing Part B premium, which is the same for all Part B enrollees regardless of income, the supplemental premium would increase according to the enrollee's adjusted gross income ("AGI").

The supplemental premium would be mandatory for individuals eligible to receive Part A coverage in order to avoid the adverse selection problem (i.e., withdrawal by the healthier part of the population) that could occur if a substantial premium were imposed on a voluntary basis. The effect of adverse selection could be to increase the per enrollee cost of Medicare and thus require that the supplemental premium be raised to retain budget neutrality.

The Committee decided that the supplemental premium should be less than the portion of the value of the Medicare coverage received that is not paid for by the basic premium or employee pay-

roll taxes. Therefore, the maximum supplemental premium was set at 33 percent of the portion of Medicare coverage not paid for the the beneficiary (i.e., 50 percent of Part A coverage and the excess of the value of Part B coverage over the Part B premium).

Explanation of provision

In general, under the bill, an individual (other than certain individuals described below) who is eligible in any year for Medicare Part A coverage by reason of eligibility for social security, railroad retirement, disability, or end-stage renal disease benefits, and who is not required to pay the Part A premium, would be required to pay a supplemental premium based on the individual's AGI for that year.[1] This premium would not be treated as a medical expense for purposes of section 213, which allows a deduction for medical expenses in excess of 7.5 percent of AGI. The premium would be paid and collected in the same manner as an income tax.

Amount of the premium

Under the bill, the amount of the premium imposed on any medicare-eligible individual would be determined for taxable years beginning in 1988 under the following table:

If the adjusted gross income for the taxable year is:		The annual premium per Medicare-eligible individual is:
Over	But not over	
$0	$6,000	$0
$6,000	$6,143	$10
$6,143	$6,287	$20
$6,287	$6,430	$30
$6,430	$6,573	$40
$6,573	$6,716	$50
$6,716	$6,860	$60
$6,860	$7,003	$70
$7,003	$7,146	$80
$7,146	$7,289	$90
$7,289	$7,433	$100
$7,433	$7,576	$110
$7,576	$7,719	$120
$7,719	$7,862	$130
$7,862	$8,006	$140
$8,006	$8,149	$150
$8,149	$8,292	$160
$8,292	$8,436	$170
$8,436	$8,579	$180
$8,579	$8,722	$190
$8,722	$8,865	$200
$8,865	$9,009	$210
$9,009	$9,152	$220
$9,152	$9,295	$230
$9,295	$9,438	$240
$9,438	$9,582	$250
$9,582	$9,725	$260
$9,725	$9,868	$270
$9,868	$10,011	$280

[1] In addition, enrollees in Part B are required to pay an additional $1 per month Part B premium beginning in 1990 and an additional $.40 per month beginning in 1991. (See sec. 206 of the bill.) These additional premiums are to be indexed in the same manner in which the Part B premium is currently indexed.

If the adjusted gross income for the taxable year is:		The annual premium per Medicare-eligible individual is:
Over	But not over	
$10,011	$10,155	$290
$10,155	$10,298	$300
$10,298	$10,441	$310
$10,441	$10,585	$320
$10,585	$10,728	$330
$10,728	$10,871	$340
$10,871	$11,014	$350
$11,014	$11,158	$360
$11,158	$11,301	$370
$11,301	$11,444	$380
$11,444	$11,587	$390
$11,587	$11,731	$400
$11,731	$11,874	$410
$11,874	$12,017	$420
$12,017	$12,160	$430
$12,160	$12,304	$440
$12,304	$12,447	$450
$12,447	$12,590	$460
$12,590	$12,734	$470
$12,734	$12,877	$480
$12,877	$13,020	$490
$13,020	$13,163	$500
$13,163	$13,307	$510
$13,307	$13,450	$520
$13,450	$13,593	$530
$13,593	$13,736	$540
$13,736	$13,880	$550
$13,880	$14,023	$560
$14,023	$14,166	$570
$14,166		$580

The annual premium determined under the above table would be pro-rated based on the number of months an individual is a medicare-eligible individual during the taxable year. The same proration rule is to apply in the case of a short taxable year, except that in such case, the individual's adjusted gross income would be annualized (assuming that the individual would have received adjusted gross income at the same rate for a full 12 months).

Special rule for joint returns

In the case of a joint return, the premium table would be applied separately to each spouse who is a medicare-eligible individual. For this purpose, the AGI of each spouse would be deemed to be one-half of the couple's combined AGI under the joint return.

Adjustment of the premium table for years after 1988

By December 15 of 1988, and of each subsequent calendar year, the Secretary would prescribe an adjusted table applicable to taxable years beginning in the immediately succeeding calendar year. The Secretary would adjust the premium amounts by the medicare inflation factor. Each other dollar amount would be adjusted by the cost-of-living adjustment applicable to such year for purposes of the income tax brackets (sec. 1(f)(3) of the Code). Adjustments of amounts in the table would be rounded to the nearest dollar.

The medicare inflation factor for any calendar year would be the percentage (if any) by which the medicare value for such year exceeds the medicare value for 1988. The medicare value for any year is the sum for January of such year of (1) 50 percent of the value of Part A coverage (i.e., the monthly actuarial rate established under sec. 1818(d)(1) of the Social Security Act), and (2) the excess of (a) the value of Part B coverage (i.e., twice the monthly actuarial rate established under sec. 1839(a)(1) of the Social Security Act) over (b) the monthly premium paid for such coverage.[2] For purposes of determining the premium paid for Part B coverage, the following would be disregarded: (1) any penalty premium charged to individuals who are not continuously enrolled in Part B throughout the period they are entitled to enroll in Part B (sec. 1839(b) of the Social Security Act); (2) the extra Part B premium payable by residents of a U.S. possession and by individuals who are enrolled in Part B but not Part A (sec. 1839(e)(4) and (5) of the Social Security Act discussed below); and (3) the special ceiling on premiums limiting any premium increase to the increase in an individual's social security benefit (sec. 1839(f) of the Social Security Act).

Medicare-eligible individual

In general.—Generally, an individual would be a medicare-eligible individual with respect to a month if such individual is entitled to (or, on application, with no payment, would be entitled to) Part A coverage for such month. An individual, other than a nonresident alien, would be treated as a medicare-eligible individual for the month in which he attained age 65 and any subsequent month unless such individual established to the satisfaction of the Secretary that he was not a medicare-eligible individual for such month.

Exceptions.—An individual would not be a medicare-eligible indivdual for any month for which he was (1) entitled to benefits solely because he paid a Part A premium; (2) a resident of a U.S. prossession who paid the extra Part B premium applicable only to such residents (sec. 1839(e)(4) of the Social Security Act); or (3) a qualified nonresident.

A qualified nonresident would be an individual (1) who had received no medical services during the current and four preceding taxable years for which payment was or would be made under Medicare Part A; (2) who was not entitled to Medicare Part B benefits at any time during the current and four preceding taxable years; and (3) who had been present in a foreign country or countries for at least 330 full days during the 12-month period ending at the close of the current taxable year and each of the four consecutive preceding 12-month periods. In the year of death, the 330 day test would be satisfied if the decedent spent more than 90 percent of the days preceding the death in a foreign country or countries.

The exemption for Part A enrollees who pay the Part A premium was based on the fact that such enrollees already paid for the full cost of Part A coverage. The residents of United States possessions were excepted because they paid an additional Part B premium for the new catastrophic benefits. Qualified nonresidents were

[2] Under the Social Security Act, the monthly actuarial rates for Part A and Part B coverage are estabished prior to December 15 of the preceding year.

viewed as, in effect, not receiving coverage under Part A and thus were exempt from the supplemental premium.

Treatment as a tax

For purposes of the rules regarding payment (including estimated payments) and collection of taxes (Subtitle F), the supplemental premium would be considered an income tax. In addition, the supplemental premium would not be treated as a medical expense for purposes of section 213, which allows a deduction for medical expenses in excess of 7.5 percent of AGI.

It would not however, be considered an income tax for purposes of determining either the amount of any credits allowable against income tax or the alternative minimum tax (sec. 55). Section 15, relating to changes in tax rates, would not apply to the supplemental premium.

Information reporting

The bill would require the Secretary of Health and Human Services to make an information return stating (1) the name, address, and taxpayer identification number of each individual who is entitled to Part A coverage without payment for any month during the calendar year (other than an individual who is: (a) entitled to Medicare Part A solely by reason of the payment of a Part A premium; on (b) resident of a U.S. possession who pays the extra Part B premium applicable only to such residents (sec. 1839 (e)(4)), and (2) the number of months such taxpayer is so entitled.

Effective date

The supplemental premium provision of the bill would be effective for taxable years beginning after December 31, 1987.

TITLE II—PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM

Sec. 201. Limitation on Medicare out-of-pocket expenses under Part B

Present law

(a) Limitation on Medicare out-of-pocket expenses under part B.—Under current law any Medicare beneficiary who is entitled to Medicare Hospital Insurance (Part A) benefits is automatically enrolled and covered for Supplementary Medical Insurance benefits (Part B), unless the person indicates he does not want to be covered for such benefits. Those not entitled to Medicare Hospital Insurance benefits may voluntarily elect to enroll in the Supplementary Medical Insurance program.

In general, the Supplementary Medical Insurance benefits program is financed through premium payments by enrollees ($17.90 a month in 1987), together with contributions from general revenue funds appropriated by the Federal government, and certain deductible ($75 in 1987) and cost-sharing (coinsurance) provisions.

The Supplementary Medical Insurance benefits program pays for certain physician services, and other outpatient services including X-Ray, laboratory tests, durable medical equipment, prosthetic devices, and certain therapies.

Under current law, there are certain cost sharing requirements. Before Medicare makes any payment for covered expenses during any calendar year, the individual must meet an annual deductible of $75. The deductible must be made up of "covered" expenses—that is, expenses which would, except for the deductible, constitute incurred expenses with respect to which benefits are otherwise payable.

Medicare beneficiaries must pay coinsurance amounts for covered Part B services under current law. Services by a physician or supplier of services under the Supplementary Medical Insurance program are generally reimbursed under Medicare on a "reasonable charge" basis. Medicare reimburses 80 percent of covered "reasonable charges" (or in some cases, the "reasonable costs") and beneficiaries are responsible for the remaining 20 percent in coinsurance payments. Beneficiaries are also responsible for any amount above the "reasonable charge" or "reasonable cost" determination.

Payment of a Part B blood deductible is also required under current law. A beneficiary is required to pay a separate deductible equal to the cost of the first three pints of whole blood (or equivalent quantities of red blood cells) furnished to a beneficiary in an outpatient setting during a calendar year. However, if the beneficary arranges for the replacement on a pint-for-pint basis, the beneficiary may not be charged the deductible.

The Committee believes that out-of-pocket costs for Part B services have become an increasing burden to Medicare beneficiaries. The General Accounting Office (GAO), in a recent report entitled "Medicare and Medicaid Effects of Recent Legislation on Program and Beneficiary Costs," found that beneficiary out-of-pocket cost per capita for Part B services increased from $395 in 1980 to $516 in 1985, about a thirty-one percent increase.

(b) Limitation on charges where catastrophic limit is reached.—Under current law institutional providers of services with agreements with the Medicare program may charge Medicare beneficiaries coinsurance amounts under the Part B program.

The Committee believes it must ensure that institutional providers (i.e., hospitals) not charge Medicare beneficiaries coinsurance once the beneficiary has reached the Part B catastrophic limit, whereby, Medicare would pay 100 percent of the reasonable charge, or in some cases, the reasonable cost allowed.

Explanation of provision

(a) Limitation on Medicare out-of-pocket expenses under part B.—After a Medicare beneficiary has incurred out-of-pocket Part B covered expenses in a calendar year which exceeded the Part B catastrophic limit: (1) Medicare would pay 100 percent of reasonable charges (or in some cases, the reasonable costs) for any additional Part B covered services in the year, and (2) no further deductibles would be required. Amounts above the full Medicare level paid to physicians who did not accept assignment would not be included in the catastrophic limit.

Out-of-pocket Part B expenses would be defined to include the Part B $75 deductible, the Part B blood deductible, the 20 percent coinsurance required to be paid by beneficiaries for Part B benefits and $250 of reimbursable outpatient mental health services.

The Part B catastrophic limit would be $1,043 in 1989. For succeeding years, the limit would equal the limit for the preceding year, increased by the cost-of-living adjustment to Social Security benefits. Because of the need to ensure that the overall catastrophic proposal is budget neutral, the Part B limit will not become effective until January, 1989, and is therefore, $1,000 plus the projected cost-of-living adjustment, or $1,043, for that year.

For prepaid health care organizations paid on the basis of aggregate reasonable cost, the Secretary would be required to provide for an appropriate adjustment to their payment amounts to reflect the increase in protection as if payment were made on an individual-by-individual basis.

(b) Limitation on charges where catastrophic limit is reached.—Institutional providers of services with agreements with the Medicare program would be prohibited from charging Medicare beneficiaries for services for which catastrophic benefit payments are made to the provider.

Effective date

The limitation on out-of-pocket expenses would be effective for services provided on or after January 1, 1989.

Sec. 202. Extending home health services

Present law

Under current law home health services are covered under Medicare if: (1) the services are ordered by and included in the plan of treatment established by a physician; (2) the services are required on an intermittent basis; (3) the services are performed by or under the direct supervision of a licensed nurse; and (4) the services are reasonable and necessary for the treatment of an illness or injury.

To meet the requirement for intermittent skilled nursing care, an individual must have a medically predictable recurring need for skilled nursing services. Current guidelines generally define intermittent as permitting daily skilled nursing visits for up to eight hours a day for up to two to three weeks if medically reasonable and necessary. Daily is defined as five days per week.

The Committee believes that the intermittent rule has created an unnecessary barrier to receiving home health services. The Committee believes that daily care should be available on the weekends as well as during the week and that allowing for only three weeks of continuous care in a given period does not meet the needs of many Medicare beneficiaries.

Explanation of provision

The intermittent skilled nursing care definition for home health services would be expanded so that "daily" would be defined as seven days per week and care would be provided for up to 35 days in a given period. A beneficiary could receive more than 35 days of consecutive home health services if the physician certified that the beneficiary required a subsequent period based on certification of exceptional circumstances requiring such services.

All other Medicare home health requirements would continue to apply. All that would be changed would be the definition of daily to

mean seven days a week and that the intermittent rule would not become operative until a Medicare beneficiary required daily care under this new definition. In these cases, a Medicare beneficiary could only receive care for up to 35 consecutive days in a given period, except by physician certification of exceptional circumstances.

Effective date

The change in the intermittent care rule would be effective for services furnished on or after January 1, 1989.

Sec. 203. Increase in maximum payment allowed for outpatient mental health services

Present law

Under current law the maximum reimbursement for services provided by a psychiatrist or non-psychiatric physician providing for outpatient treatment of mental, psychoneurotic, or personality disorder is $250 per calendar year for each Medicare beneficiary. Medicare only recognizes a maximum of 62.5 percent of $500 of charges, or $312.50, and will reimburse 80 percent of this amount or $250. Consequently, the effective coinsurance rate is 50 percent for the first $500 of outpatient mental health services.

The amount of Medicare reimburseable mental health services has not changed since the Medicare program was instituted in 1965. The Subcommittee believes that the $250 limit for mental health services has not kept pace with inflation and should be raised in order to provide a reasonable mental health benefit. If the $250 limit had been adjusted for inflation, it is estimated that the benefit would now be worth over $2,000. Increasing the outpatient benefit should reduce the current incentive for hospitalizing those with mental disorders.

Explanation of provisions

The current law maximum reimbursement for services provided by a psychiatrist or non-psychiatric physician providing for outpatient treatment of mental, psychoneurotic, or personality disorders would be raised to $1,000 per calendar year for each Medicare beneficiary. The coinsurance requirement would remain the same. Thus, Medicare would recognize up to 6.5 percent of $2,000 of charges or $1,250, and would reimburse 80 percent of this amount or $1,000. Amounts in excess of current reimburseable limits ($250) would not be counted towards the Part B catastrophic limit.

The $1,000 reimbursement limitation per calendar year applies only to expenses incurred for physicians' services and any items or supplies furnished by the physician in his office in connection with the treatment for a mental, psychoneurotic or personality disorder.

As under current law, services by other health personnel, including home health services, outpatient hospital services and services furnished in a community mental health center, would not be subject to the special psychiatric limitation even though the services are in connection with a condition included in the definition of "mental, psychoneurotic and personality disorder." Further, as under current law, the services of auxiliary personnel who are ren-

dering services "incident to" the physician's professional service would not be included in the $1,000 reimbursement limitation.

Effective date

The expanded outpatient mental health benefit would become effective for services provided on or after January 1, 1989.

Sec. 204. Mailing of notice of Medicare benefits and participating physician directories

Present law

Under current law the Social Security Administration annually publishes a "Medicare Handbook," which expalins Medicare coverage and describes in general what Medicare does not cover. The Social Security Administration also publishes annually directories by geographic area of physicians who participate in the Medicare program. Under the Omnibus Reconciliation Act of 1986, these directories are to be made available in Social Security officers and hospitals, and a notice explaining that the directories are free upon request is to be included with the Soecial Security check mailed to beneficiaries in April.

The Committee believes that the passage of Medicare catastrophic legislation will result in some uncertainty on the part of Medicare beneficiaries about what the new benefits do and do not include. In is also the belief of the Committee that the method by which the participating physician directories are currently distributed is too cumbersome a process.

Explanation of provision

The Secretary would be required to distribute annually a notice to all Medicare beneficiaries (whether they receive benefits under Part A or B) which would provide a simple, clear explanation of Medicare benefits and the health care services from which benefits are not available. This notice would also include a general explanation of the limits of the Medicare and Medicaid programs with regard to long term care benefits.

In addition, a directory of participating physicians would be sent to each beneficiary each year starting in January, 1988 by Medicare carriers. Directories would be organized regionally to facilitate their use by beneficiaries. One or more directories would be used in each carrier service area as appropriate. Physicians would be listed by specialty and locality.

Currently, funding for the distribution of the participating physician directories comes from the Medicare carriers' budgets. It is the expectation of the Committee that the Appropriation Committee will provide additional funding for the carriers' to cover the cost of mailing a directory to every Medicare beneficiary each year.

Effective date

The provision would first apply to annual notices and directories for 1988. The annual notice would be sent by January 31, 1988, or 3 months after the date of enactment of this legislation.

Sec. 205. Providing additional medical assistance for Indigent Medicare beneficiaries

Present law

Under current law, eligibility of the elderly and the disabled for Medicaid is linked to actual or potential receipt of cash assistance under the Federal Supplemental Security Income (SSI) program. The income and resource eligibility criteria for the Medicaid differ substantially among the states. All state Medicaid plans, except for Wyoming, pay the monthly Medicare Part B premium payment for their dual eligible beneficiaries who are cash assistance SSI recipients under a "buy-in" agreement. If a state does not buy-in for Part B coverage on behalf of cash assistance beneficiaries, it cannot receive Federal matching payments for medical services which would have been covered under Medicare if there had been a buy-in arrangement. The Federal government does match state payments for copayments for cash assistance beneficiaries. States may pay the Medicare coinsurance (generally 20 percent of the "reasonable charge") and deductible amounts in full; States may also pay lesser amounts.

Public Law 99-509 created an optional categorically needy group composed of the elderly and disabled with incomes up to the Federal poverty level. A State choosing this option could pay all Medicare cost sharing for these individuals and if so, was also required to cover some newly eligible pregnant women and children. States are required to use the SSI resources standard or a higher resource standard in determining eligibility.

As a result of the catastrophic coverage provided by this legislation, States would pay a reduced amount for those individuals for whom they currently pay the Medicare deductibles and coinsurance. It is the belief of the Committee that the States should use these savings to improve benefits for the indigent elderly and disabled.

Currently, none of the States buy into the Medicare program for all of the elderly whose incomes are below the Federal Census Bureau poverty level, now $5,255 for single elderly individuals and $6,628 for a couple in 1987. The Congressional Budget Office, in 1986, estimates that about 3.3 million of the elderly had incomes below for Federal Poverty level, but only 1.1 million are covered under Medicaid. The 2.2 million individuals not now receiving Medicaid are also most likely to lack private Medigap insurance and least likely to be able to afford Medicare's cost sharing requirements.

Explanation of provisions

The Federal Supplemental Security Income (SSI) program would be amended to establish a separate category of elderly and disabled for whom state Medicaid programs, including states operating under Section 1115(a) waivers, would be required to pay the Medicare premium, deductibles and coinsurance amounts. Federal matching payments would be available for these expenses under the same formula states are currently reimbursed under the Medicaid program.

Although states are required to cover Medicare's cost sharing requirements under this proposal, States would be permitted to utilize the Section 1843 mechanism to implement their Medicare "buy-in" programs to cover Medicare eligible individuals.

All elderly and disabled with incomes up to the Federal Census Bureau poverty level (i.e. incomes up to $5,255 for an elderly individual and $6,628 for a couple in 1987) and who meet the resource standard would be entitled to participate in this program. States would be required to use the SSI resource standards, or a higher resource standard, in determining eligibility

This proposal would not require the States to make payment for regular Medicaid benefits.

Effective date

The States would be required to pay the (1) monthly premium for months beginning with July, 1988, and (2) items and services furnished on and after July 1, 1988.

Sec. 206. Adjustment in Medicare Part B premium

Present law

(a) Transitional Adjustments in 1990 and 1991.—Under current law premiums for Part B of Medicare are paid on a monthly basis according to an amount established in advance for each calendar year. The current method (effective for 1984–1988) of determining the monthly premium is to use a formula that sets the premium rate at 25 percent of the amount needed, in the aggregate, to cover program costs for aged beneficiaries. In the case of beneficiaries who have their premiums deducted from their Social Security checks, if there is a Social Security cost-of-living adjustment that is less than the amount for the increased premium, the premium increase otherwise applicable for 1987 or 1988 will be reduced to avoid a reduction in the beneficiaries' Social Security checks.

For calendar years beginning in 1989, the calculation of the Part B premium will return to prior law so that the premium rate will be the lower of: (1) an amount sufficient to cover one-half of the costs of the program for the aged or (2) the current premium amount increased by the percentage by which cash benefits were increased under the cost-of-living adjustment (COLA) provisions of the Social Security program.

To assure that the total catastrophic proposal is revenue neutral for fiscal years 1988 through 1992, a small additional premium will be necessary in 1990, 1991, 1992.

(b) Part B premium for residents of U.S. Commonwealths and Territories.—Under current law all Medicare beneficiaries who voluntarily enroll in Part B of Medicare are subject to the same Part B premium payment rules and receive the same Medicare benefits, notwithstanding that they may reside in the American Commonwealths of Puerto Rico and Northern Mariana Islands or the Territories of Guam, the Virgin Islands, and America Samoa.

Concern has been expressed by some of the Commonwealths and Territories that if their residents, who are Medicare beneficiaries, are not required to share in the cost of the catastrophic benefits contained in this legislation, as are Medicare beneficiaries in the

States, then their Medicare beneficiaries will not be entitled to Medicare catastrophic benefits provided in this legislation.

It is the Committee's intention to finance all of the catastrophic benefits in 1988 and 1989 from a supplemental premium charged Medicare beneficiaries who file a Federal Income Tax Return. As each Commonwealth and Territory has its own internal revenue code that is not amended by Federal legislation and the residents of these U.S. possession are not subject to the Federal Internal Revenue Code unless they have U.S. source income, it is the Committee's belief that some alternative method of payment is necessary in order to require Medicare beneficiaries in the U.S. possessions to pay their fair share of the cost of the catastrophic benefits.

Because Medicare beneficiaries in the U.S. possessions are subject to payment of the Part B premium if they voluntarily enroll in Part B, the Committee believes that requiring an additional premium to the current Part B premium for these Medicare beneficiaries is the most equitable and administratively feasible method of collecting revenue to finance the catastrophic benefits in the U.S. possessions.

(c) Part B premium for individuals enrolled under part B but not entitled to benefits under part A.—Under current law individuals aged 65 and over who are not Social Security beneficiaries and therefore not entitled to Medicare Part A benefits may voluntarily elect to enroll in Medicare Part B. These individuals pay the same premium as is charged all other Medicare beneficiaries who enroll in Part B and are entitled to the same benefits as other Medicare Part B beneficiaries.

Because these individuals will not be subject to the Medicare supplemental premium collected through the Federal income tax code, it is the Committee's intent to charge these beneficiaries an additional premium which would be added to their Part B premium. In this manner, these beneficiaries will help finance the Part B catastrophic benefits.

Explanation of provision

(a) Transitional adjustments in 1990 and 1991.—The monthly Part B premium for each Medicare beneficiary voluntarily enrolled in Part B for each month in calendar year 1990 would be $1.00 greater than the amount otherwise determined under current law. For calendar year 1991 the monthly Part B premium would be 40 cents greater than the amount otherwise determined under current law following the $1.00 increase in 1990. The net effect, according to CBO estimates, would be to increase the Part B premium by approximately $1.50 a mounth in 1991 and 1992 above current law Part B monthly premium amounts. In later years, as in current law, the Part B premium would increase (1) by an amount sufficient to cover one-half of the costs of the program for the aged or (2) by an amount increased by the percentage increase in the Social Security cost-of-living adjustment (COLA) increase, whichever is smaller.

(b) Part B premium for residents of U.S. Commonwealths and Territories.—In the case of a resident of the Commonwealths of Puerto Rico or Northern Mariana Islands of Territories of Guam, the Virgin Islands or America Samoa, of the United States who

voluntarily enrolls in Medicare Part B the monthly Part B premium otherwise determined for that Medicare beneficiary in 1988 or 1989 would be increased by an amount that would equal one twelfth of the product of the average per capital additional benefits contained in this legislation (and related administrative costs), as determined by the Secretary during September of the previous year and the ratio of (1) the per capita actuarial value of the benefits under Parts A and B for residents of the Commonwealth or Territory who are entitled to Medicare Parts A and B benefits, to (2) the per capita actuarial value of the benefits under Parts A and B for resident of the United States who are entitled to Medicare Part A and B benefits.

In 1990, the monthly Part B premium beneficiaries would pay would be the sum of: (1) the current law Part B premium in 1989, (2) the amount added in 1989 for residents in each Territory or Commonwealth and (3) would be increased by the percentage of an amount sufficient to cover one-half of the costs of the program for the aged or by an amount increased by the percentage increase in the Social Security cost-of-living adjustment (COLA) increase, whichever is smaller.

For subsequent years the Part B monthly premium would be increasd by current law provisions.

The monthly Part B premium assessed Medicare beneficiaries in the Commonwealths and Territories would not include the additional premium amounts described in section (a) above as beneficiaries in the Commonwealths and Territories would be required to pay the value of the additional benefits through the additional premium assessed under this section.

(c) Part B Premium for Individuals Enrolled Under Part B But Not Entitled to Benefits Under Part A.—The monthly Part B premium for Medicare beneficiaries entitled to benefits under Part B but not entitled to (or, on application without payment of an additional premium, would not be entitled to) benefits under Part A, would be in 1989, (1) the monthly premium otherwise determined for the individual under current law, (2) and increased by an amount equal to one-twelfth of the average, per capita additional benefits (and related administrative costs) the Secretary estimates (during September of 1988) would be payable for the additional benefits contained in this legislation.

In 1990, the monthly Part B premium beneficiaries would pay would be the sum of: (1) the current law Part B premium in 1989, (2) plus the amount added in 1989 for the Part B buy-in only beneficiaries and (3) would be increased by the percentage of an amount sufficient to cover one-half or the costs of the program for the aged or by an amount increased by the percentage increase in the Social Security cost-of-living adjustment (COLA) increase, whichever is smaller.

For subsequent years the part B monthly premium would be increased by current law provisions.

Effective date

(a) The provision would apply to monthly premiums for months beginning with January 1990. (b) The provision would apply to monthly premiums for months beginning with January 1988. (c)

The provision would apply to monthly premiums for months beginning with Januray 1989.

Sec. 207. Changes in certification of Medicare supplemental health insurance policies.

Present law

(a) Establishment of New Medigap Standards.—Under current law Medicare supplemental health insurance policies (Medigap policies) must meet minimum standards before companies can market them as Medigap policies. The Standards are contained in a model state program approved by the National Association of Insurance Commissioners (NAIC) on June 1, 1979, and incorporated in section 1882 of the Social Security Act. This section is commonly referred to as the "Baucus Amendment."

The standards contained in section 1882 require Medigap policies to: (1) cover all of the Medicare Part A inpatient coinsurance for the 61st through 90th day in the hospital, and the 91st through 150th day lifetime reserve days, plus 90 percent of covered hospital inpatient expenses for a lifetime maximum of up to 365 days after the insured has exhausted Medicare benefits; (2) cover the Medicare Part B coinsurance, which may be subject to a $200 deductible and a maximum benefit of $5,000 per year; (3) cover the Part A and B blood deductibles; (4) not define preexisting conditions more restrictive than as a condition that was diagnosed or treated within 6 months before the effective date of the policy; (5) automatically change as Medicare's deductibles and coinsurance requirements change; (6) have a "free look" period, during which an individual may return an unwanted policy for cancellation and receive a full refund of any premium paid; (7) provide cancellation and termination clauses to be prominently displayed; and (8) at the time of sale, provide a buyer's guide explaining benefits and limitations of Medicare supplemental insurance.

In addition, loss ratio targets were established for Medigap policies that set a goal for the percentage of insurance premiums to be returned to policyholders in the form of benefits. Medigap policies must be expected to pay benefits at least equal to 60 percent of the earned premiums for individual policies and 75 percent for group policies.

There are Federal sanctions, consisting of fines and/or imprisonment, for (1) furnishing false information to obtain the Secretary's certification, (2) posing as a Federal agent to sell Medigap policies, (3) knowingly selling policies that duplicate coverage the individual already has, and (4) selling supplemental policies by mail in states that have not approved, or are deemed not to have approved, their sale.

(b) Required mailing of notice.—Under current law there is no requirement that Medicare supplemental health insurance companies send a notice to their policyholders explaining changes made by the Congress and how this affects the premium charged.

(c) Required submission of advertising.—Under current law there is no requirement that Medicare supplemental health insurance companies submit for review their advertising copy to State Insurance Commissioners.

(d) Transition for current policies.—Under current law, whoever knowingly sells a health insurance policy to an individual entitled to Medicare Part A or enrolled in Medicare Part B, with knowledge that such policy substantially duplicates health benefits under the Medicare program, is considered guilty of a felony and upon conviction may be fined not more than $25,000 or imprisoned for not more than 5 years, or both.

The Committee believes that because the Federal Minimum Benefit Requirements for Medigap policies contained in the Baucus Amendment include benefits that are in the catastrophic proposal, there is a need to amend the Federal law and in particular to waive the Federal penalties for duplication of Medicare benefits for some period in order to give States the opportunity to change their minimum benefit requirements for Medigap policies.

In order to reduce the confusion about Medicare benefits once catastrophic legislation is enacted, the Committee believes that Medigap insurers should be required to inform their policyholders of the changes in Medicare benefits and submit their advertising to State Insurance Commissioners.

Explanation of provisions

(a) Recommendations for new standards.—The Secretary of Health and Human Services, taking into consideration the Medicare catastrophic legislation passed by the Congress and any recommendations developed by the National Association of Insurance Commissioners, would be required to report to the Congress within 150 days after enactment his recommendations for changes that should be made in the Federal requirements contained in Section 1882 of the Social Security Act for certification of Medicare Supplemental policies.

It is the sense of Committee that Congress would promptly act on such recommendations and provide for appropriate changes in the Federal standards, for whcih states would adjust their laws in a timely manner.

(b) Required mailing of notice.—Medicare Supplemental policies in effect on Janury 1, 1988, would be required, on a one time basis by January 31, 1988, to send a letter to their Medicare policyholders that explains the improved benefits contained in the catastrophic legislation passed by the Congress and how these improvements will affect the benefits contained in the medigap policies and the cost of the medigap premium.

(c) Required submission of advertising.—Companies providing Medicare supplemental policies would be required to submit their advertising (whether through the written, radio or television medium) to each State Insurance Commissioner (or comparable officer identified by the Secretary) in which they do business for review as to whether their marketing practices comply with state law.

The Committee intends that advertising copy would be submitted for review but that the company could use the advertisement, whether written, by radio or television medium, without waiting for formal approval of the advertising copy.

The Committee further wishes to clarify that only the advertisement to be shown to consumers be submitted for review and not

financial or other records surrounding the advertisement copy be submitted to the State Insurance Commissioner or other body designated by the State.

(d) Transition for current policies.—The Federal penalties for noncompliance with the substantial duplication of health benefit requirements contained in Section 1882 of the Social Security Act for existing Medicare supplemental health insurance policies would be suspended for the period January 1, 1988, and ending on December 31, 1989. However, new policies issued as of January 1, 1988, would still be subject to the penalties of fines of not more than $25,000 or imprisonment for not more than 5 years, or both, after Medicare catastrophic legislation is enacted.

Sec. 208. Extension of social HMO demonstration projects

Present law

Under Sec. 2355 of the Deficit Reduction Act of 1984 the Secretary of Health and Human Services approved waivers to establish a project to demonstrate the concept of a social health maintenance organization. The four demonstration sites selected were: SCAN Health Plan, Inc. Long Beach, California; Kaiser Permanente Medicare Plus II, Portland Oregon; Seniors Plus, Minneapolis, Minnesota; and Elderplan, Inc., Brooklyn, New York. These sites are to provide for the integration of health and social services under the direct financial management of a provider of services. The Social HMOs are to enroll Medicare beneficiaries voluntarily in the HMO model and services are financed on a prepaid, capitated, at-risk basis. Operations began in the spring of 1985 and are scheduled to end in the fall of 1988.

Because the demonstration sites have had some difficulty in enrolling a sufficient number of Medicare beneficiaries and therefore have not had an adequate amount of time to properly study the concept of a social HMO, the Committee believes that the waivers for the four demonstration sites should be extended.

Explanation of provision

The Secretary of Health and Human Services would be directed to extend without interruption, through September 30, 1992, the waivers granted under Sec. 2355 of the Deficit Reduction Act of 1984 for the social HMO demonstration project under the same terms and conditions (other than duration of the project) established under Sec. 2355. The Social HMOs would be at full risk in the third year and succeeding years. An interim report to Congress would be due by December, 1988, and a final report to Congress on the project would be due not later than March 31, 1993.

Sec. 209. Study on comprehensive medical coverage under the Medicare Program

Present law

There is no study now being conducted on the cost of expanding the Medicare program to provide comprehensive medical services, including long term care, either under a capitation arrangement or by a fee for service method of payment.

Because of the strong interest on the part of several Members of Congress and other interested parties that Medicare be expanded to include services not now covered under the Medicare program, in particular long term care, the Committee believes that a study should be conducted to assess, the need for, and costs of, providing these services under the Medicare program.

Explanation of provision.

The General Accounting Office (GAO) would be requested to conduct a study to assess the need for, and cost of, the following services in the Medicare program for Medicare beneficiaries: (1) an annual preventive care visit which would include diagnostic procedures performed during annual physician examination, including (as medically appropriate by sex) a routine Papanicolaou test, blood test for cholesterol levels, colorectal exam, and a mammogram, (2) an annual vision examininations and the dispensing of prescription eyeglasses, (3) dental services, including an annual dental examination and cleaning, tooth extractions, simple restorations, services required for dentures, surgical preparation of endentulous ridges, periodontal therapy and endodontics, (4) biannual hearing threshold testing and hearing aids for those with a significant hearing loss, (5) comprehensive long-term care services (including adult day care services, intermediate care facility services, home and community based services, outpatient drug therapy, and respite care) provided on a case-managed basis in the environment of least restriction, where approved and regularly recertified by a geriatric assessment team, and (6) prescription drugs and biologicals.

The GAO would be directed to make separate determinations of the cost of each of the services described above on the basis of fee-for service reimburement and on the basis of a comprehensive captitation payment arrangement. Cost estimates would be determined for 1988 and the succeeding four years.

Effective data

The GAO would be required to report to the Congress on the results of the study not later than six months after the date of the enactment of this Act.

Sec. 210. Research on long-term care for Mediare beneficiaries

Present law

The Federal government has funded some research on the delivery and cost of long term care for the Medicare population for a number of years, but essential data is still lacking and there has been no effort to coordinate the findings from these earlier studies.

Knowing that a greater proportion of the American population will require long term care services in the coming decades, it is the belief of the Committee that there is insufficient data for the Committee to make informed decisions concerning the delivery and cost of providing long term care under the Medicare program.

Explanation of provision

The Secretary of Health and Human Services would be required to provide for a new progam of research on issues relating to the delivery and financing of long term care for Medicare beneficiaries.

There would be authorized to be appropriated, in equal parts from the Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, $5 million each fiscal year from 1988 through 1992 to carry out the new research projects.

The new research projects would be in addition to the current level of effort by the Health Care Financing Administration's Office of Research and Demonstrations, the National Center for Health Services Research, the National Institute on Aging, and the Office of the Assistant Secretary for Planning and Evaluation.

This new research would focus on issues of delivering and financing long term care and would include at least the following areas: (1) the financial characteristics of Medicare beneficiaries who receive or need long-term care services, including whether such beneficiaries are eligible for Medicaid benefits for such care, (2) how the financial and other characteristics of Medicare beneficiaries affect their utilization of institutional and noninstitutional long-term care services, (3) how relatives of Medicare beneficiaries are affected financially and in other ways because the beneficiaries require or receive long-term care services, (4) the quality of long-term care services (in community-based and custodial settings) and how the provision of long-term care services may reduce expenditures for acute health care services, and (5) the effectiveness of consumer protections in the States and at the Federal level which assure adequate access to long term care (other than in a nursing home) and protect the rights of Medicare beneficiaries.

VI. Budget Effects of the Bill

1. COMMITTEE ESTIMATE

In compliance with clause 7(a) of Rule XIII of the Rules of the House of Representatives, the following statement is made: the Committee agrees with the estimate prepared by the Congressional Budget Office (CBO) which is included below. This estimate indicates that the combined costs and revenues in the bill will not add to the budget deficit, but indeed reduce the deficit slightly. The revenue estimate from the Joint Committee on Taxation is also included below.

A summary of the direct spending and revenue impact of the bill is shown in the table below:

[By fiscal year, in millions of dollars]

	1988	1989	1990	1991	1992
Outlays (direct spending)	1,025	3,880	5,410	6,330	7,445
Revenues	1,421	5,018	5,888	6,641	7,550
Net impact upon deficit	−396	−1,138	−478	−311	−105

2. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES

In compliance with clause 2(l)(3)(B) of Rule XI of the Rules of the House of Representatives, the Committee states that the letter from the Congressional Budget Office indicates that there is a change in budget authority and that there are no new or increased tax expenditures as a result of the bill.

3. COST ESTIMATE PREPARED BY THE CONGRESSIONAL BUDGET OFFICE

In compliance with clause 2(l)(3)(C) of Rule XI of the Rules of the House of Representatives requiring a cost estimate prepared by the Congressional Budget Office, the following report prepared by CBO is provided.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: H.R. 2470.
2. Bill title: The Medicare Catastrophic Protection Act of 1987.
3. Bill status: As ordered reported by the Committee on Ways and Means on May 19, 1987.
4. Bill purpose: To amend title XVIII of the Social Security Act to provide protection against catastrophic medical expenses under the Medicare program, and for other purposes.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Direct spending/offsetting receipts:					
Section 101 provisions:					
Eliminating the limit on covered hospital days:					
Budget authority	−10	−30	−60	−90	−130
Outlays	180	300	345	380	420
Eliminating enrollees' copayments for hospital coinsurance and reserve days:					
Budget authority	−15	−50	−95	−150	−210
Outlays	295	485	560	615	680
Limiting payment of the hospital deductible to the first stay each year:					
Budget authority	−20	−60	−110	−160	−220
Outlays	395	530	550	595	655
Indexing the first-stay hospital deductible amount to the COLA:					
Budget authority	(1)	−5	−15	−35	−65
Outlays	10	75	175	290	410
Changing the calculation of the part A premium:					
Budget authority	15	25	25	25	25
Outlays	15	25	25	25	25
Effect on turst fund from change in part A premium:					
Budget authority	−16	−27	−30	−30	−35
Outlays	0	0	0	0	0
Section 102 provisions:					
Changing the requirements for coinsurance on SNF stays, and covering up to 150 days a year:					
Budget authority	−10	−30	−55	−85	−120
Outlays	170	275	315	350	385
Eliminating the prior hospitalization requirement of coverage of SNF stays:					
Budget authority	(1)	−2	−5	−10	−15
Outlays	0	40	55	65	75

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Section 103 provisions:					
Eliminating the 210 day limit on hospice benefits:					
Budget authority	(1)	(1)	(1)	(1)	(1)
Outlays	(1)	1	1	1	1
Section 104 provisions					
Changing blood deductible requirements from 3 per spell to 3 a year:					
Budget authority	(1)	−1	−2	−5	−5
Outlays	5	8	10	10	11
Section 105 provisions:					
Transfering home health benefits to part B:					
Effect on part A:					
Budget authority	0	130	445	865	1,360
Outlays	0	−2,896	−4,440	−5,106	−5,867
Effect on part B:					
Budget authority	0	3,435	4,690	5,270	6,075
Outlays	0	2,896	4,440	5,106	5,867
Section 201 provisions:					
Benefits from the cap on part B copayments:					
Budget authority	0	2,445	3,760	4,480	5,330
Outlays	0	2,065	3,515	4,310	5,125
Section 202 provisions:					
Extending home health benefits to 35 consecutive days:					
Budget authority	0	180	255	285	330
Outlays	0	155	240	275	315
Section 203 provisions:					
Increasing limit on payments for outpatient mental health services to $1,000 a year:					
Budget authority	0	100	200	270	350
Outlays	0	85	185	255	335
Section 205 provisions:					
Requiring state Medicaid programs to buy-in all Medicare beneficiaries with incomes below the poverty line:					
Budget authority	40	225	275	325	360
Outlays	40	225	275	325	360
Section 206 provisions:					
Adjusting part B premium:					
Budget authority	−5	−60	−370	−610	−685
Outlays	−5	−60	−370	−610	−685
Spending under Medicaid:					
Effects of Medicare provisions on Federal Medicaid costs:					
Budget authority	−85	−330	−470	−560	−660
Outlays	−85	−330	−470	−560	−660
Total direct spending/offsetting receipts:					
Budget authority	−106	5,945	8,438	9,785	11,685
Outlays	1,025	3,880	5,410	6,330	7,445
Amounts subject to appropriations:					
Section 201 provisions:					
Administrative costs to implement copayment cap:					
Outlays	30	30	20	20	20
Section 204 provisions:					
Annual notice to enrollees of benefits under Medicare (half from HI; half from SMI):					
Outlays	4	4	4	4	4
Mailing directories of participating physicians to all enrollees:					
Outlays	25	25	25	25	25
Section 210 provisions:					
Providing research funding on long-term care (half from HI; half from SMI):					
Outlays	5	5	5	5	5
Total amounts subject to appropriations:					
Outlays	64	64	54	54	54

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Revenues:					
Section 106 provisions:					
Imposing an income-related supplemental premium: [1]					
Revenues	1,421	5,018	5,888	6,641	7,550
Total:					
Budget authority	−106	5,945	8,438	9,785	11,685
Outlays	1,089	3,994	5,464	6,384	7,499
Revenues	1,421	5,018	5,888	6,641	7,550
Change in deficit	−332	−1,074	−424	−257	−51

[1] Less than $0.5 million.

Note: Components may not sum to total due to rounding.

The effects of this bill fall within function 570 and function 550.

1. Estimates are from the Joint Committee on Taxation.

Basis of estimate

Under current law, Part A of Medicare (Hospital Insurance) pays most of the costs for Medicare-covered services provided by hospitals, skilled nursing facilities (SNFs), home health agencies, and hospices. Enrollees share the costs of services through a variety of copayment requirements, most of which are related to the first-day hospital deductible amount (which was $520 in 1987). The bill would change the HI copayment requirements, effective January 1, 1988, with the result that Medicare's reimbursement costs would increase. It would also change the way in which the HI premium is calculated, which would affect only those enrollees not already entitled to HI benefits through previous payroll tax contributions.

Part B of Medicare (Supplementary Medical Insurance) pays for services provided by physicians, independent laboratories, and hospital outpatient departments. Under current law, SMI enrollees are responsible for the first $75 of covered medical expenses, plus 20 percent of all reasonable charges above the deductible amount. This bill would alter copayment requirements under Part B of Medicare by capping each enrollee's annual liability for copayments, first effective for calendar year 1989. It would also provide some expansion of mental health and home health benefits.

Over the five-year projection period, the additional benefits provided under this bill would be financed by increases in the SMI premium and by implementation of a new income-related premium collected through the income tax system.

Estimates of the costs to Medicare from the copayment provisions of this bill were derived by simulating the effects of proposed changes on a 1 percent random sample of Medicare enrollees (about 300,000 enrollee records). Medicare reimbursement and copayment costs for these enrollees in 1985 under current law were aged to 1988 through 1992, using CBO's baseline projections for enrollment and reimbursements, separately for each major service category. Total Medicare reimbursements under current law were compared to what reimbursements would be after implementation of the proposed provisions to obtain the estimated costs of the benefit expansion.

Under current law, Medicare reimbursements per enrollee are projected to increase by about 9.6 percent annually between 1987 and 1992. Under this bill, reimbursements per enrollee would increase by an estimated 10.9 percent annually over the same period. About 85 percent of the additional benefit costs would be due to the assumption by Medicare of some enrollees' copayment liabilities for current services. The remaining 15 percent of estimated costs would be due to increased use of Medicare-covered services by enrollees. The utilization responses assumed in the estimate were based on regression analyses of health care use by Medicare enrollees with and without supplementary insurance coverage for their Medicare copayment costs, using 1984 Health Insurance Survey data.

The revenue estimates for the income-related premiums were obtained from the Joint Committee on Taxation, and were based on simulations on a stratified random sample of current income tax returns, projected through 1992.

The specific provisions of the bill are explained in detail below. Unless otherwise indicated, the provisions would take effect on January 1, 1988.

Direct spending/offsetting receipts

Section 101 provisions

Section 101 of the bill contains five provisions, discussed in turn below. The estimates in this section take account of Medicare's additional reimbursements to hospitals to compensate for Medicare enrollees' bad debt—that is, the failure by some enrollees to pay the deductible and coinsurance amounts for which they are liable. Estimates by the Inspector General of the Department of Health and Human Services indicate that about 4 percent of enrollees' copayment liabilities for hospital stays are bad debt, which is eventually paid by Medicare.

Eliminating the limit on covered hospital days.—Under current law, Medicare will cover up to 90 days during each spell of illness, plus an additional lifetime reserve of up to 60 days. In addition, there is a lifetime reserve of 190 days for inpatient psychiatric care. This bill would eliminate the limit on covered hospital days for general care, but would retain the lifetime limit for inpatient psychiatric care. Only a fraction of a percent of enrollees (fewer than 0.1 percent) exhaust their hospital benefits for general inpatient care each year, but the costs such patients incur are substantial. Covering these days would cost Medicare $180 million in fiscal year 1988. This estimate is based on information provided by the Health Care Financing Administration, indicating that this provision would add about 0.5 percent to total inpatient costs for Medicare-covered inpatient stays.

Eliminating enrollees' copayments for hospital coinsurance and reserve days.—Under current law, enrollees pay one-fourth of the first-day hospital deductible amount for days 61–90 in a given spell of illness (coinsurance days), and one-half of the deductible amount for any lifetime reserve days used. This bill would eliminate enrollees' liability for coinsurance and reserve days. About 0.5 percent of HI enrollees used coinsurance or reserve days each year, account-

ing for an estimated 2.3 million coinsurance days and 0.7 million reserve days in 1988. Eliminating these inpatient coinsurance costs would cost Medicare $295 million in fiscal year 1988.

Limiting payment of the hospital deductible to the first stay each calendar year.—Under current law, enrollees are liable for a hospital deductible each time they are admitted to the hospital in a new spell of illness (which begins on the 61st day following discharge from a previous inpatient episode). In 1988, about 800,000 enrollees will pay more than one first-day deductible under current law, while no one would be liable for more than one deductible each year under this bill. In addition, the bill contains as hold-harmless provision that would protect enrollees who were readmitted after January 1, 1988, within a spell of illness that had begun prior to that date from paying another deductible for such admissions. These provisions would cost Medicare an estimated $395 million in fiscal year 1988.

Indexing the first-stay hospital deductible to the COLA.—Under current law, the first-day deductible is tied to increases in the index used to update payment rates under the prospective payment system. Under this bill, the deductible would instead be tied to increases in the (third-quarter) consumer price index (the Social Security COLA). This would slow the rate of growth in the deductible, because the update factor is projected to increase by 35 percent from 1987 to 1992, while the COLA will increase by only 23 percent over the same period. In 1988, the deductible would be $544 under current law, but would be $541 if indexed to the COLA instead. By 1992, the deductible would increase to $700 under current law, but would be only $641 if indexed to the COLA. The additional costs to Medicare of this provision (after implementing all of the inpatient copayment provisions discussed above, as well as the SNF copyment provision discussed below) would be $10 million in fiscal year 1988.

Changing the calculation of the Part A premium.—Under current law, the premium charged to HI enrollees who are not entitled to benefits through previous payroll tax contributions is based on the first-day deductible amount. Under this bill, the method of determining the premium would be changed so that it would reflect the actuarial value of HI benefits. This would reduce the projected monthly premium amount for 1988 from $236 to $155, affecting about 23,000 enrollees. The costs to Medicare from this provision in fiscal year 1988 would be about $15 million.

Section 102 provisions

Section 102 contains provisions relating to Medicare coverage of stays in skilled nursing facilities. They would change coinsurance requirements, provide for coverage of up to 150 days a year, and eliminate the 3-day prior hospitalization requirement for covered SNF care.

Changing the requirements for coinsurance on SNF stays, and covering up to 150 days a year.—The bill would alter the way in which enrollees' coinsurance liability for stays in skilled nursing facilities is determined, and would change Medicare's coverage limits from 100 days per spell to 150 days a year. Under current law, coinsurance amounts equal to one-eighth of the hospital de-

ductible amount ($68 per day in 1988) are charged each day for days 21-100 in SNFs during each spell of illness. Under the bill, enrollees would pay coinsurance amounts equal to 20 percent of Medicare's national average reasonable cost for the first seven days of each SNF stay; enrollees' coinsurance costs would be $23.50 per day in 1988 for each of the first seven days of each SNF stay.

Fewer than 2 percent of Medicare enrollees have covered SNF stays, but these enrollees will use about 8.6 million SNF days during 1988. These provisions would increase Medicare costs by $170 million in fiscal year 1988. About 80 percent of the costs would be due to lower coinsurance amounts paid by enrollees, while the remaining 20 percent of costs would be due to additional covered SNF days resulting from the change in coverage limits to 150 days a year. The estimate assumes that those enrollees who would exhaust their SNF coverage under current law (about 7,500 in 1988) would use the full 150 days allowed under the bill.

Eliminating the prior hospitalization requirement for SNF stays.—This bill would remove the requirement that a Medicare enrollee be hospitalized for at least three days prior to admission to a SNF to be eligible for Medicare coverage, effective January 1, 1989. As a result, the number of people receiving the SNF benefit would increase. Increased costs resulting from this provision are estimated at $40 million for fiscal year 1989, based on findings from a demonstration and study conducted by the Health Care Financing Administration.

Section 103 provisions

Section 103 of the bill would eliminate the current 210-day lifetime limit on the number of days enrollees who are terminally ill may receive hospice services. Nearly 98 percent of hospice beneficiaries die before the 210-day limit is reached, but tabulations by the Health Care Financing Administration indicate that those who survive for the full 210 days of their hospice benefit live another 50 days, on average. Because not all of these additional Medicare costs under the hospice benefit would be offset by reduced costs for inpatient, SNF, or home health services, there would be a small cost due to this provision, eqaual to about $0.4 million in fiscal year 1988.

Section 104 provisions

Under current law, enrollees are required to replace or pay for the first 3 pints of blood used each spell of illness. Section 5 of the bill would require enrollees to replace or pay for the first 3 pints of blood used each year. Medicare costs would increase under this provision because enrollees would pay for an estimated 156,000 fewer pints of blood used in 1988 then they would under current law, costing Medicare about $50 per pint. The additional costs to Medicare in fiscal year 1988 would be about $5 million.

Section 105 provisions

This section of the bill would transfer the financing for home health benfits from the HI trust fund to the SMI trust fund for all Part B enrollees, effective January 1, 1987. Medicare beneficiaries who are not enrolled under Part B could continue to receive home

health benefits under Part A. This would generate not net outlays costs, but it would alter budget authority totals under the two trust funds.

Section 201 provisions

Under Section 201 of the bill, each SMI enrollee's liability for copayments under the program would be capped at $1,043 in 1989. In subsequent years, the value of the copayment cap would increase at the same rate as the third-quarter Consumer Price Index (the Social Security COLA). Under CBO's baseline projections, the COLA would increase by about 4 percent annually over the five-year projection period, so that the SMI copayment cap would be $1,185 in 1992.

About 8.4 percent (or 2.7 million) of SMI enrollees would be affected by the copayment cap in 1989. As a result, SMI benefit costs would increase by $2.1 billion in fiscal year 1989. By 1992, more than 10 percent of enrollees would be affected by the copayment cap, at a cost to Medicare of $5.1 billion during the first year.

Section 202 provisions

Currently, Medicare enrollees are entitled to receive two to three weeks of daily home health visits. This bill would increase the limit to 35 days, and would clarify current law by specifying that "daily care" means up to 7 days a week. The estimated cost of this provision, which would be effective January 1, 1989, is $155 million for fiscal year 1989. The estimate is based on Medicare administrative data on the distribution of home health visits under current law, and on projections of the increased utilization that would result from clarifying the definition of daily care and increasing the limit on consecutive days.

Section 203 provisions

Current law limits reimbursement for outpatient mental health services to $250 a year per enrollee. This bill would increase the limit to $1,000 a year, effective for calendar year 1989. The coinsurance rate on the additional benefits would remain at 50 percent, as under current law, and the additional copayments resulting from this provision would not count toward the SMI copayment cap described elsewhere in this bill. The estimate costs for this provision are $85 million in fiscal year 1989. The estimate is based on current use rates for the mental health benefit and projected increases in utilization due to the higher limit. The estimates of increased utilization were based on results of a demonstration study of a similar benefit expansion conducted by the Department of Health and Human Services.

Section 205 provisions

Currently, state Medicaid programs may choose whether or not to pay Medicare premium and copayment costs for all Medicare enrollees with incomes below the poverty level. This bill would require states to cover these costs, thereby affecting approximately 46 states that do not currently provide this Medicaid benefit to all poor Medicare enrollees, effective July 1, 1988. The estimated costs of this provision are $40 million in fiscal year 1988. The cost esti-

mate is based on counts from the Current Population Survey of poor Medicare enrollees who do not receive Medicaid benefits, and on Medicaid program data showing the current cost of the proposed benefits per Medicare-eligible Medicaid beneficiary.

Section 206 provisions

This section provides for several adjustments to the current-law SMI premium. For most SMI enrollees, the SMI premium would be increased by $1.00 a month in 1990, and by an additional $0.40 a month in 1991, on top of the automatic increases that would result under current law. (Under current law, beginning in 1989 SMI premium increases may not exceed the rate at which Social Security benefits are adjusted each year to offset cost-of-living increases, as measured by the change in the third-quarter Consumer Price Index. This is referred to as the COLA.)

Two groups are exempt from the ad hoc premium increases described above, however, and would be subject to a different set of provisions. For residents of Puerto Rico and the other territories, the current-law SMI premium would be increased in 1988 and 1989 by the full insurance value of the new Medicare HI and SMI benefits provided under this bill. For U.S. residents who are enrolled in Part B but who are not eligible for Part A benefits, the current-law SMI premium would be increased in 1989 by the insurance value of the new Medicare SMI benefits provided under this bill. Beginning in 1990 and for all subsequent years, the total premium paid in 1989 by both groups of these enrollees would be indexed to the COLA.

The net effect of thse premium provisions would to generate additional premium receipts of $5 million fiscal year 1988, growing to $685 million by fiscal year 1992.

Federal Medicaid savings

About 9 percent of Medicare enrollees are dually eligible for Medicaid benefits. For these enrollees, Medicaid generally pays both their copayment liabilities under Medicare and their SMI premium costs. Consequently, Medicaid costs would be reduced by this bill because of lower copayment costs for dually-eligible enrollees, partially offset by increased Medicaid costs for the higher SMI premiums. In addition, there would be some additional savings to Medicaid in states with "medically needy" programs because the copayment limitations provided under this bill would reduce the number of Medicare enrollees who would qualify for Medicaid benefits under such programs. Savings are estimated to be $85 million in fiscal year 1988.

Amounts subject to appropriations

Section 201 provisions

Neither Medicare carriers nor the Health Care Financing Administration currently collect information on the amounts of coinsurance paid by enrollees for Part B benefits. To implement the copayment cap proposed in this bill, comprehensive information about both deductible and coinsurance amounts paid under Part B would have to be complied across all Medicare carriers for each

SMI enrollee. The estimates of start-up and ongoing administrative costs under this proposal are based on discussions with the Bureau of Program Operations in the Health Care Financing Administration.

Section 204 provisions

Under this provision, the Department of Health and Human Services would be required annually to mail each HI or SMI enrollee an explantation of Medicare benefits, beginning with calendar year 1988. The funds would be taken equally from the HI and the SMI trust funds. Estimated costs for this provision are $4 million annually, based on previous experience with such mailings by the Social Security Administration and by the Health Care Financing Administration.

In addition, the Department would be required to mail annually a directory of participating physicians to each SMI enrollee, beginning calendar year 1988. The costs of this provision are estimated to be $25 million a year, again based on previous experience by the Social Security and the Health Care Financing administrations.

Section 210 provisions

Section 210 authorizes an appropriation of $5 million annually for each year from 1988 through 1992, to conduct research on long term care services for Medicare enrollees. The funds would be taken equally from the HI and the SMI trust funds.

Revenues

Section 106 provisions

This section would impose an income-related, tax-based supplementary premium on all people eligible for benefits under Part A of Medicare, excluding nonresidents, effective January 1, 1988. For individuals who were eligible for only part of the year, this supplementary premium would be pro-rated for the part of year during which they were Medicare-eligible. The supplementary premium rates would be indexed to the rate of growth in the subsidy value of Medicare benefits. The Joint Tax Committee estimates that revenues from this income-related premium would total $1.4 billion in fiscal year 1988.

6. Estimated savings to State and local governments: This bill would have an effect on State and local government budgets, since States share in the financing of Medicaid—paying about 45 percent of outlays. CBO estimates the following effects:

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Effects on State/local Medicaid costs	−70	−270	−385	−460	−540

7. Estimate comparison: None.

8. Previous CBO estimates: H.R. 1280 and H.R. 1281.

Estimate prepared by: Sandra Christensen, Hinda Ripps Chaikind, Holly Harvey, and Don Muse.

10. Estimated approved by: C.G. Nuckols (for James L. Blum, Assistant Director for Budget Analysis).

IV. Other Matters Required To Be Discussed Under the Rules of the House

1. VOTE OF THE COMMITTEE

In compliance with clause 2(l)(2)(B) of Rule XI of the Rules of the House of Representatives, the following statement is made: the bill, H.R. 2470 was ordered favorably reported to the House of Representatives on May 19, 1987, by voice vote.

2. OVERSIGHT FINDINGS

In compliance with clause 2(l)(3)(A) of Rule XI of the Rules of the House of Representatives, the Committee reports that the need for this legislation was confirmed by the oversight hearings of the Subcommittee on Health.

The Subcommittee conducted a total of eight hearings on the legislation including six hearings on extending catastrophic coverage under the Medicare program (January 29, 1987; February 25, 1987; March 3, 1987; March 4, 1987, March 10, 1987; and March 30, 1987). The Subcommittee conducted a hearing March 31, 1987, on the feasibility of financing and delivery a long-term care benefit under the Medicare program and a hearing April 23, 1987, on extending coverage of prescription drugs under the Medicare program.

3. OVERSIGHT BY COMMITTEE ON GOVERNMENT OPERATIONS

In compliance with clause 2(l)(3)(D) of Rule XI of the House of Representatives, the Committee states that no oversight findings and recommendations have been submitted to the Committee on Government Operations with respect to the subject matter contained in the bill.

4. INFLATION IMPACT

In compliance with clause 2(l)(4) of Rule XI of the Rules of the House of Representatives, with regard to the inflationary impact of the report bill, the Committee believes that the bill has no measurable effect on health care prices or consumer prices generally as the bill is budget neutral in each of the five years for which cost estimates are available.

V. Changes in Existing Law Made by the Bill, As Reported

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Social Security Act

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TITLE XVI—SUPPLEMENTAL SECURITY INCOME FOR THE AGED, BLIND, AND DISABLED

* * * * * * *

MEDICAL ASSISTANCE FOR POOR AGED, BLIND, AND DISABLED INDIVIDUALS

SEC. 1622. For purposes of title XIX of this Act in the case of a State (as such term is used for purposes of this title XVI) and for purposes of any State program of medical assistance operating under a waiver approved under section 1115(a), each individual—

(1) who, but for income and resources, would be an eligible individual and is not otherwise eligible for medical assistance under that title or program,

(2) who is entitled to hospital insurance benefits under part A of title XVIII (including entitlement by reason of an enrollment under section 1818),

(3) whose income (as determined under this title) does not exceed 100 percent of the weighted average poverty threshold (as calculated by the Bureau of the Census for the second previous calendar year) applicable, as the case may be, to a family unit of one person 65 years and over or to a two person family unit with a householder 65 years and over, and

(4) whose resources (as determined under this title) do not exceed the resource level described in section 1905(p)(1)(D), or, at a State's option, a resource level established by the State under section 1905(p)(2)(B),

shall, without regard to section 1902(f), be eligible for medical assistance to the same extent and under the same conditions as a qualified Medicare beneficiary (described in section 905(p)(1)) would be eligible for medical assistance under the plan under clause (VIII) of section 1902(a)(10), section 1902(n), and section 1916(b), if the State had elected the option described in section 1902(a)(10)(E). For purposes of section 1903(a)(1), these individuals shall be considered to be qualified Medicare beneficiaries. Coverage of individuals under this section shall not be considered, for purposes of section 1902(m)(3), to be coverage of individuals under section 1902(a)(10)(E).

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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NOTICE OF MEDICARE BENEFITS

Sec. 1804. (a) The Secretary shall distribute annually a notice containing—

(1) a clear, simple explanation of the benefits available under this title and health care services for which benefits are not available under this title, and

(2) a description of the limited benefits for long-term care services availble under this title and generally available under State plans approved under title XIX.

Such notice shall be mailed annually to individuals entitled to benefits under part A or part B of this title.

(b) There are authorized to be appropriated in equal proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund such sums as may be required to provide for the annual publication and distribution of the notice described in subsection (a).

PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

DESCRIPTION OF PROGRAM

SEC. 1811. The insurance program for which entitlement is established by sections 226 and 226A provides basic protection against the costs of [hospital, related post-hospital] *inpatient hospital services, extended care services* home health services, and hospice care in accordance with this part for (1) individuals who are age 65 or over and are eligible for retirement benefits under title II of this Act (or would be eligible for such benefits if certain government employment were covered employment under such title) or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under title II of this Act (or would have been so entitled to such benefits if certain government employment were covered employment under such title) or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

SCOPE OF BENEFITS

SEC. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on this behalf or, in the case of payments referred to in section 1814(d)(2) to him (subject to the provisions of this part) for—

[(1)] inpatient hospital services for up to 150 days during any spell of illness minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);]

(1) inpatient hospital services;

(2)[(A) post-hospital] extended care services for up to [100 days during any spell of illness, and (B) to the extent provided in subsection (f), extended care services that are not post-hospital extended care services] *150 days during any calendar year;*

(3) *subject to subsection (f),* home health services; and

(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each [and one], *a* subsequent period of 30 days, *and a subsequent extension period* with respect to which the individual makes an election under subsection (d)(1).

(b) Payment under this part for services furnished an individual [during a spell of illness may not (subject ot subsection (c))] *may not* be made for—

[inpatient hospital services furnished to him during such spell after such services have been furnished to him for 150 days during such spell minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);]

[(2) post-hospital] *(1)* extended care services furnished to him [during such spell after such services have been furnished to him for 100 days during such spell] *during a calendar year after such services have been furnished to the individual for 150 days during that year;* or

[(3)] *(2)* inpatient psychiatric hospital services furnished to him after such services have been furnished to him for a total of 190 days during his lifetime.

[(c) If an individual is an inpatient of a psychiatric hospital on the first day of the first month for which he is entitled to benefits under this part, the days on which he was an inpatient of such a hospital in the 150-day period immediately before such first day shall be included in determining the number of days limit under subsection (b)(1) insofar as such limit applies to (1) inpatient psychiatric hospital services, or (2) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness (but shall not be included in determining such number of days limit insofar as it applies to other inpatient hospital services or in determining the 190-day limit under subsection (b)(3).]

(c)(1) If an individual is an inpatient of a psychaiatric hospital on the first day of medicare entitlement (as defined in paragraph (4)(A)) payment may not be made under this part during the period described in paragraph (2) for inpatient mental health services (as defined in paragraph (4)(B)) in excess of the number of days specified in paragraph (3).

(2) The period described in this paragraph—

(A) begins on the first day of medicare entitlement, and

(B) ends at the end of the first period of 60 consecutive days thereafter on each of which the individual is not receiving inpatient mental health services.

(3) The number of days specified in this paragraph for an individual is 150 days less the number of days (during the 150-day period immediately before the first day of medicare entitlement) during which the individual was an inpatient of a psychiatric hospital.

(4) In this subsection:

(A) The term "first day of medicare entitlement" means, for an individual, the first day of the first month for which the individual is entitled to benefits under this part.

(B) The term "inpatient mental health services" means—

(i) inpatient psychiatric hospital services, and

(ii) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness.

(d)(1) Payment under this part may be for hospice care provided with respect to an individual only during two periods of 90 days each [and one subsequent period of 30 days], *a subsequent period of 30 days, and a subsequent extension period* during the individual's lifetime and only, with respect to each such period, if the individual makes an election under this paragraph to receive hospice care under this part provided by, or under arrangements made by, a particular hospice program instead of certain other benefits under this title.

(2)(A) * * *

(B) After an individual makes such an election with respect to a 90- or 30-day period *or a subsequent extension period* the individual may revoke the election during the period, in which case—

(i) * * *

* * * * * * *

(e) For purposes of subsections (b) and (c), inpatient hospital services, inpatient psychiatric hospital services, and [post-hospital] extended care services shall be taken into account only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1814(a), made with respect to such services under this part.

[(f)(1) The Secretary shall provide for coverage, under clause (B) of subsection (a)(2), of extended care services which are not post-hospital extended care services at such time and for so long as the Secretary determines, and under such terms and conditions (described in paragraph (2)) as the Secretary finds appropriate, that the inclusion of such services will not result in any increase in the total of payments made under this title and will not alter the acute care nature of the benefit described in subsection (a)(2).

[(2) The Secretary may provide—

[(A) for such limitations on the scope and extent of services described in subsection (a)(2)(B) and on the categories of individuals who may be eligible to receive such services, and

[(B) notwithstanding sections 1814, 1816(v), and 1886, for such restrictions and alternatives on the amounts and methods of payment for services described in such subsection, as may be necessary to carry out paragraph (1).

[(g) For definition of "spell of illness", and for definitions of other terms used in this part, see section 1861.]

(f) Subsection (a)(3) shall only apply to home health services provided to an individual during a month in which the individual is not entitled to benefits under part B.

DEDUCTIBLES AND COINSURANCE

SEC. 1813. (a)(1) The amount payable for inpatient hospital services furnished an individual during [any spell of illness] *the first period of continuous hospitalization (as defined in subsection (b)(3)) that begins in a calendar year* shall be reduced by a deduction equal to the inpatient hospital deductible *for that calendar year* or, if less, the charges imposed with respect to such individual for such

services, except that, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be charges so imposed. [Such amount shall be further reduced by a coinsurance amount equal to—

[(A) one-fourth of the inpatient hospital deductible for each day (before the 91st day) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 60 days during such spell; and

[(B) one-half of the inpatient hospital deductible for each day (before the day following the last day for which such individual is entitled under section 1812(a)(1) to have payment made on his behalf for inpatient hospital services during such spell of illness) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 90 days during such spell;

except that the reduction under this sentence for any day shall not exceed the charges imposed for that day with respect to such individual for such service (and for this purpose, if the customary charages for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed).]

[(2) The amount payable to any provider of services under this part for services furnished an individual during any spell of illness shall be further reduced by a deduction equal to the cost of the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to him as part of such services during such spell of illness.]

(2)(A) The amount payable to any provider of services under this part for services furnished an individual shall be further reduced by a deduction equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during each calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

(B) The deductible under subparagraph (A) for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1833(b) to blood or blood cells furnished the individual in the year.

(3) The amount payable for post-hospital extended care services furnished an individual during any spell of illness shall be reduced by a coinsurance amount equal to one-eight of the inpatient hospital deductible for each day (before the 101st day) on which he is furnished such services after such services have been furnished to him for 20 days during such spell.]

(3)(A) The amount payable for extended care services furnished an individual in any calendar year shall be reduced by the coinsurance amount (promulgated under subparagraph (C) for that year) for each day (before the 8th day) on which he is furnished such services during the year.

(B) Before September 1 of each year (beginning with 1987), the Secretary shall estimate the national average per diem reasonable cost recognizea under this title for extended care services which will be furnished in the succeeding calendar year.

(C) The Secretary shall, in September of each year (beginning with 1987) promulgate the coinsurance amount which shall apply to extended care services furnished in the succeeding year. Such amount shall be equal to 20 percent of the national average per diem cost estimated under subparagraph (B) in that year. If the coinsurance amount determined under the preceding sentence is not a multiple of 50 cents, it shall be rounded to the nearest multiple of 50 cents (or, if it is a multiple of 25 cents but not a multiple of 50 cents, to the next higher multiple of 50 cents).

* * * * * * *

[(b)(1) The inpatient hospital deductible for 1987 shall be $520. The inpatient hospital deductible for any succeeding year shall be an amount equal to the inpatient hospital deductible for the preceding calendar year, changed by the applicable percentage increase (as defined in section 1886(b)(3)(B)) which is applied under section 1886(d)(3)(A) for discharges in the fiscal year that begins on October 1 of such preceding calendar year, and adjusted to reflect changes in real case mix (determined on the basis of the most recent case mix data available). Any amount determined under the preceding sentence which is not a multiple of $4 shall be rounded to the nearest multiple of $4 (or, if it is midway between two multiples of $4, to the next higher mulitiple of $4).

[(2) The Secretary shall promulgate the inpatient hospital deductible and all coinsurance amounts under this section between September 1 and September 15 of the year preceding the year to which they will apply.

[(3) The inpatient hospital deductible for a year shall apply to—

[(A) the deduction under the first sentence of subsection (a)(1) for the year in which the first day of inpatient hospital services occurs in a spell of illness, and

[(B) to the coinsurance amounts under subsection (a) for inpatient hospital services and post-hospital extended care services furnished in the year.]

(b)(1) The inpatient hospital deductible for 1987 shall be $520. The inpatient hospital deductible for any succeeding year shall be an amount equal to the inpatient hospital deductible for the preceding year increased by the applicable increase percentage determined under section 215(i) in the previous year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

(2) Not later than November 15 of each year (beginning with 1987), the Secretary shall promulgate the inpatient hospital deductible under the subsection for the succeeding year.

(3) In this section, the term "period of continuous hospitalization" means, with respect to an individual, the period beginning on the first day the individual is furnished inpatient hospital services and ends on the individual's date of discharge (as established by the Secretary for purposes of section 1886) from the hospital (or, in the case of a transfer, hospital) involved.

CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICE

Requirement of Requests and Certifications

SEC. 1814. (a) Except as provided in subsections (d) and (g) and in section 1876, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

(1) * * *

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

(A) * * *

(B) in the case of [post-hospital] extended care services, such services are or were required to be given because the indivudual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis[, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services];

* * * * * * *

(6) with respect to inpatient hospital services or [post-hospital] extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 186(k)(4), including any finding made in the course of a sample or other review of admissions to the institution) pursuant to the system of utilization review that further inpatient hospital services or further post-hosptial extended care services, as the case may be, are not medically necessary; except that, it such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or skilled nursing faciltiy, as the case may be received notice of such finding; and

(7) in the case of hospice care provided an individual—

(A)(i) in the first 90-day period—

(I) the individual's attending physician (as defined in section 1861(dd)(3)(B)), and

(II) the medical director (or physician member of the interdisciplinary group described in section 1861(dd)(2)(B)) of the hospice program providing (or arranging for) the care,

each certify, not later than two days after hospice care is initiated, that the individual is terminally ill (as defined in section 1861(dd)(3)(A)), [and]

(ii) in a subsequent 90- or 30-day period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period the individual is terminally ill[;], *and*

(iii) in a subsequent extension period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill;

* * * * * * *

Payments for Emergency Hospital Services

(d)(1) * * *

* * * * * * * *

(3) The amounts payable under the preceding paragraph with respect to services described therein shall, subject to the provisions of section 1813, be equal to [60] *100* percent of the hospital's reasonable charges for routine services furnished in the accommodations occupied by the individual or in semiprivate accommodations (as defined in section 1861(v)(4)), whichever is less, plus [80] *100* percent of the hospital's reasonable charges for ancillary services. If separate charges for routine and ancillary services are not made by the hospital, reimbursement may be based on [two-thirds of] the hospital's reasonable charges for the services received but not to exceed the charges which would have been made if the patient had occupied semiprivate accommodations. For purposes of the preceding provisions of this paragraph, the term "routine services" shall mean the regular room, dietary, and nursing services, minor medical and surgical supplies and the use of equipment and facilities for which a separate charge is not customarily made; the term "ancillary services" shall mean those special services for which charges are customarily made in addition to routine services.

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HOSPITAL INSURANCE BENEFITS FOR UNINSURED INDIVIDUALS NOT OTHERWISE ELIGIBLE

Sec. 1818. (a) * * *

* * * * * * *

[(d)(1) The monthly premium of each individual for each month in his coverage period before July 1974 shall be $33.

[(2) The Secretary shall, during the next to last calendar quarter of each year determine and promulgate the dollar amount (whether or not such dollar amount was applicable for premiums for any prior month) which shall be applicable for premiums for months occurring in the following calendar year. Such amount shall be equal to $33, multiplied by the ratio of (A) the inpatient hospital deductible for that following calendar year, as promulgated under section 1813(b)(2), to (B) such deductible promulgated for 1973. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1, or, if a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1.]

(d)(1) The Secretary shall, during September of each year (beginning with 1987), estimate the monthly actuarial rate for months in the succeeding year. Such actuarial rate shall be one-twelfth of the amount which the Secretary estimates (on an average, per capita basis) is equal to 100 percent of the benefits and administrative costs which will be payable from the Federal Hospital Insurance Trust Fund for services performed and related administrative costs incurred in the succeeding year with respect to individuals age 65 and over who will be entitled to benefits under this part during that entire year.

(2) The Secretary shall, during September of each year determine and promulgate the dollar amount which shall be applicable for premiums for months occurring in the following year. Such amount shall be equal to the monthly actuarial rate determined under paragraph (1) for that following year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

(3) Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium under this section, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for individuals 65 and older as provided in paragraph (1).

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PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * * * *

SCOPE OF BENEFITS

SEC. 1832. (a) * * *

(b) For definitions of [“spell of illness”,] “medical and other health services”[,] and other terms used in this part, see section 1861.

PAYMENT OF BENEFITS

SEC. 1833. (a) * * *

* * * * * * *

(c) Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections [(a) and (b)] *(a), (b), and (f)* only whichever of the following amounts is the smaller:

(1) [$312.50] *$1,250*, or

(2) 62½ percent of such expenses.

* * * * * * *

(g) In the case of services described in the second sentence of section 1861(p), with respect to expenses incurred in any calendar year, no more than $500 shall be considered as incurred expenses for purposes of subsections [(a) and (b).] *(a), (b), and (f).* In the case of outpatient occupational therapy services which are described in the second sentence of section 1861(p) through the operation of section 1861(g), with respect to expenses incurred in any calendar year, no more than $500 shall be considered as incurred expenses for purposes of subsections [(a) and (b).] *(a), (b), and (f).*

* * * * * * *

AMOUNTS OF PREMIUMS

SEC. 1839. (a) * * *

(b) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837, the monthly premium [determined under subsection (a) or (e)] *otherwise determined under this section (without regard to subsection (f))* shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which he reenrolled, but there shall not be taken into account months during which the individual has attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1862(b)(3)(A)(iv) by reason of the individual's (or the individual's spouse's) current employment or months during which the individual has not attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a large group health plan as an active individual (as those terms are defined in section 1862(b)(4)(B)). Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have.

* * * * * * *

(e)(1) * * *

* * * * * * *

(3)(A) Notwithstanding the provisions of subsection (a), the monthly premium for each individual enrolled under this part for each month—

(i) in 1990 shall be $1.00 greater than the amount otherwise determined under subsection (a), and

(ii) in 1991 shall be 40 cents greater than the amount otherwise determined under subsection (a). Any increases in premium amounts taking effect under this paragraph for months in a year shall be taken into account for purposes of determining increases in each subsequent year under subsection (a)(3).

(B) Subparagraph (A) does not apply to premiums determined under paragraph (4) or (5).

(4)(A) Notwithstanding the provisions of subsection (a), in the case of an individual who is a resident of a commonwealth or territory during a month—

(i) in 1988 or 1989, the monthly premium otherwise determined for the individual under paragraph (1) or subsection (a)(3), respectively, shall be increased by the amount described in subparagraph (B) for that month; or

(ii) in a subsequent year, the monthly premium which shall apply shall be the amount described in subparagraph (C) for that month.

(B) The amount described in this subparagraph for a month in 1988 or 1989 for an individual residing in a particular commonwealth or territory is 1/12th of the product of—

(i) the average, per capita additional benefits (and related administrative costs), as determined by the Secretary during September of the previous year, that will be payable under this title during the year by reason of the amendments made by the Medicare Catastrophic Protection Act of 1987; and

(ii) the ratio (determined by the Secretary for that commonwealth or territory during September 1987) of—

(I) the per capita actuarial value of the benefits under this title for residents of the commonwealth or territory who are entitled to benefits under both part A and this part, to

(II) the per capita acturial value of the benefits under this title for residents of the United States who are entitled to benefits under both part A and this part.

(C) The amount described in this subparagraph for a month in—

(i) 1990, is the sum of—

(I) the monthly premium established under subsection (a)(3) for months in 1989, and

(II) the amount described in subparagraph (B) for months in 1989, increased by the premium percentage increase (as defined in subparagraph (E)(ii)) for 1990; or

(ii) a succeeding year is the amount described in this subparagraph for months in the previous year increased by the premiun increase percentage for that succeeding year.

(D) If any amout determined under the previous provisions of this subparagraph is not a multiple of 10 cents, the Secretary shall round the amount to the nearest multiple of 10 cents.

(E) In this paragaraph:

(i) The term "commonwealth or territory" means Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands.

(ii) The term "percentage premium increased", for a year, means the percentage determined under subsection (a)(3)(B) in the previous year.

(5)(A) Notwithstanding the provisions of subsection (a), in the case of a part B only individual (as defined in subparagraph (E)) during a month—

(i) in 1989, the monthly premium otherwise determined for the individual under subsection (a)(3) shall be increased by the amount described in subparagraph (B); or

(ii) in a subsequent year, the monthly premium which shall apply shall be the amount described in subparagraph (C) for that month.

(B) The amount described in this subparagraph is $\frac{1}{12}$th of the average, per capita additional benefits (and related administrative costs) that the Secretary estimates (during September of 1988) will be payable under this part during 1989 by reason of the amendments made by the Medicare Catastrophic Protection Act of 1987.

(C) The amount described in this subparagraph for a month—

(i) in 1990, is the sum of—

(I) the monthly premium established under subsection (a)(3) for months in 1989, and

(II) the amount described in subparagraph (B), increased by the premium percentage increase (as defined in paragraph (4)(E)(ii)) for 1990; or

(ii) in a succeeding year is the amount described in this subparagraph for months in the previous year increased by the premium increase percentage (as so defined) for that succeeding year.

(D) If any amount determined under the previous provisions of this paragraph is not a multiple of 10 cents, the Secretary shall round the amount to the nearest multiple of 10 cents.

(E) In this paragraph the term "part B only individual" means, with respect to a premiun for a month, an individual who—

(i) is not a resident of a commonwealth or territory (as defined in paragraph (4)(E)(i)) during the month,

(ii) is entitled to benefits under this part, and

(iii) is not entitled to (or, on application without payment of an addtional premium, would not be entitled to) benefits under part A.

[(f)(1) If no cost-of-living increase becomes effective under section 215(i) in December of 1985, 1986, or 1987, the monthly premium of each individual enrolled under this part for each month in the succeeding year shall (except as otherwise provided in subsection (b)) be the same as the monthly premium (disregarding subsection (b)) of the individual for such December.

[(2) If paragraph (1) does not apply to the monthly premiums for 1986, 1987, or 1988, if an individual is entitled to monthly benefits

under section 202 or 223 for Nobember and for December in the preceding year, and if the monthly premium for that December and for the following January is deducted from those benefits under section 1840(a)(1), the monthly premium for that individual for that January and for each of the succeeding 11 months for which he is entitled to benefits under section 202 or 223 shall (except as otherwise provided in subsection (b)) be the greater of—

[(A) the monthly premium amount determined under subsection (a)(2) for that January reduced by the amount (if any) by which the monthly benefit under section 202 or 223 for that November, after the deduction of the premium (disregarding subsection (b)) for that individual for that December and after rounding under section 215(g), would exceed the monthly benefit under section 202 or 223 for that December, after the deduction of the monthly premium amount determined under subsection (a)(2) (disregarding subsection (b)) for that individual for that January and after rounding under section 215(g), or

[(B) the monthly premium (disregarding subsection (b)) for that individual for that December.

For purposes of this subsection, retroactive adjustments or payments and deductions on account of work shall not be taken into account in determining the monthly benefits to which an individual is entitled under section 202 or 223.]

(f)(1) Notwithstanding subsections (a) and (b), if an individual has incurred out-of-pocket part B expenses (as defined in paragraph (2)) in a calendar year (beginning with 1989) in an amount equal to the part B catastrophic limit (established under paragraph (3)) for the year, payment under this part with respect to any additional incurred expenses in the calendar year shall be made as if—

(A) the deduction described in the second sentence of subsection (b) (relating to blood) no longer applied,

(B) "100 percent" and "0 percent" were substituted for "80 percent" and "20 percent", respectively, each place either appears in subsection (a), in section 1833(i)(2), in section 1835(b)(2), and in subsections (b)(2) and (b)(3) of section 1881.

(2) In this subsection, the term "out-of-pocket part B expenses" means—

(A) the deductions established under subsection (b), and

(B) the difference between the payment amount provided under this part and the payment amount that would be provided if "100 percent" and "0 percent" were substituted for "80 percent" and "20 percent", respectively, each place either appears in subsection (a), in section 1833(i)(2), in section 1835(b)(2), and in subsections (b)(2) and (b)(3) of section 1881.

(3)(A) The part B catastrophic limit for 1989 is $1,043. The part B catastrophic limit for any succeeding year shall be an amount equal to the part B catastrophic limit for the proceding year increased by the applicable increase percentage determined under section 215(i) in the previous year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

(B) Not later than November 15 of each year (beginning with 1988), the Secretary shall promulgate the part B catastrophic limit under this paragraph for the succeeding year.

(4) In applying paragraph (1) in the case of an organization receiving payment under clause (A) of subsection (a)(1) or under a reasonable cost reimbursement contract under section 1876—

(A) The Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect, in the aggregate, the aggregate increase in payments that would be made with respect to enrollees in the organization if payment were made other than under such clause or such a contract or with respect to individuals furnished services through the facility if payments were to be made on an individual-by-individual basis, and

(B) the organization or facility shall provide assurances satisfactory to the Secretary that the organization or facility will not undertake to charge an individual during a year for services for which payment may be made under this part after the individual has incurred (whether through the organization, facility or otherwise) out-of-pocket part B expenses in the year in an amount equal to the part B catastrophic limit established under paragraph (3) for the year.

(5) In applying paragraphs (1) and (2), the dollar amount specified in subsection (c)(1) shall be deemed to be $312.50.

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC.1842(a) * * *

* * * * * * *

(h)(1) * * *

* * * * * * *

(6) The Secretary shall provide that the directories shall be available for purchase by the public. The Secretary shall provide that each appropriate area directory is sent to each participating physician located in that area *and to each individual enrolled under this part and residing in that area* and that an appropriate number of copies of each such directory is sent to hospitals located in the area. Such copies shall be sent free of charge.

* * * * * * *

STATE AGREEMENTS FOR COVERAGE OF ELIGIBLE INDIVIDUALS WHO ARE RECEIVING MONEY PAYMENTS UNDER PUBLIC ASSISTANCE PROGRAMS (OR ARE ELIGIBLE FOR MEDICAL ASSISTANCE)

SEC. 1843. (a) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981 *or after 1987*, enter into an agreement with such State pursuant to which all eligible individuals in either of the coverage groups described in subsection (b) (as specified in the agreement) will be enrolled under the program established by this part.

* * * * * * *

(g)(1) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981 *or after 1987*, enter into a modifica-

tion of an agreement entered into with such State pursuant to subsection (a) under which the second sentence of subsection (b) shall not apply with respect to such agreement.

* * * * * * *

(h)(1) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981 *or after 1987*, enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the coverage group described in subsection (b) and specified in such agreement is broadened to include individuals who are eligible to receive medical assistance under the plan of such State approved under title XIX.

* * * * * * *

PART C—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

[Spell of Illness

[(a) The term "spell of illness" with respect to any individual means a period of consecutive days—

[(1) beginning with the first day (not included in a previous spell of illness) (A) on which such individual is furnished inpatient hospital services or extended care services, and (B) which occurs in a month for which he is entitled to benefits under part A, and

[(2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital nor an inpatient of a skilled nursing facility.]

* * * * * * *

Hospital

(e) The term "hospital" (except for purposes of sections 1814(d), 1814(f), and 1835(b), subsection (a)(2) of this section, *and* paragraph (7) of this subsection[, and subsection (i) of this section] means an institution which—

(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatient (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

* * * * * * *

[For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection.] For purposes of sections 1814(d) and 1835(b) (including determination of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections), [section 1814(f)(2), and subsection (i) of this section] *and section 1814(f)(2),* such term includes any institution which (i) meets the require-

ments of paragraphs (5) and (7) of this subsection, (ii) is not primarily engaged in providing the services described in section 1861(j)(1)(A) and (iii) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r), to inpatient diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. For purposes of section 1814(f)(1), such term includes an institution which (i) is a hospital for purposes of sections 1814(d), 1814(f)(2), and 1835(b) and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals. Notwithstanding the preceding provisions of this subsection, such term shall not[, except for purposes of subsection (a)(2),] include any institution which is primarily for the care and treatment of mental diseases unless it is a psychiatric hospital (as defined in subsection (f)). The term "hospital" also includes a Christain Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865. The term "hospital" also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this subsection and which meet the other requirements of this subsection, except that—

(A) * * *

* * * * * * *

[Post-Hospital Extended Care Services

[(i) The term "post-hospital extended care services" means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an individual after transfer from a hospital, and he shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom, if he is admitted to the skilled nursing facility (A) within 30 days after discharge from such hospital, or (B) within such time as it would be medically appropriate to begin an active course of treatment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within 30 days after discharge from a hospital; and an individual

shall be deemed not to have been discharged from a skilled nursing facility if, within 30 days after discharge therefrom, he is admitted to such facility or any other skilled nursing facility.]

Skilled Nursing Facility

(j) The term "skilled nursing facility" means (except for purposes of subsection (a)(2)) an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (1)) with one or more hospitals having agreements in effect under section 1866 and which—

(1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

* * * * * * *

except that such term shall not [(other than for purposes of subsection (a)(2))] include any institution which is primarily for the care and treatment of mental diseases. [For purposes of subsection (9)(2) such term includes any institution which meets the requirements of paragraph (1) of this subsection.] The term "skilled nursing facility" also includes an institution described in paragraph (1) of subsection (y), to the extent and subject to the limitations provided in such subsection. To the extent that paragraph (6) of this subsection may be deemed to require that any skilled nursing facility engage the services of a registered professional nurse for more than 40 hours a week, the Secretary is authorized to waive such requirement if he finds that—

(A) such facility is located in a rural area and the supply of skilled nursing facility services in such area is not sufficient to meet the needs of individuals residing therein,

(B) such facility has one full-time registered professional nurse who is regularly on duty at such facility 40 hours a week, and

(C) such facility (i) has only patients whose physicians have indicated (through physicians' orders or admission notes) that each such patient does not require the services of a registered nurse or a physican for a 48-hour period, or (ii) has made arrangements for a registered professional nurse or a physician to spend such time at such facility as may be indicated as necessary by the physician to provide necessary skilled nursing services on days when the regular full-time registered professional nurse is not on duty.

* * * * * * *

Home Health Services

(m) The term "home health services" means the following items and services furnished to an individual, who is under the care of a physican, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and servies to such individual) established and periodically reviewed by a physician, which items and services are,

except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(2) physical, occupational, or speech therapy;

(3) medical social services under the direction of a physician;

(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary;

(5) medical supplies (other than drug and biologicals) and durable medical equipment, while under such a plan;

(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital, under a teaching program of such hospital approved as provided in the last sentence of subsection (b); and

(7) any of the foregoing items and services which are provided on an outpatient basis, under arrangements made by the home health agency, at a hospital or skilled nursing facility, or at a rehabilitation center which meets such standards as may be prescribed in regulations, and—

(A) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in such place of residence, or

(B) which are furnished at such facility while he is there to receive any such item or service described in clause (A),

but not including transportation of the individual in connection with any such item or service;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital. *For purposes of paragraphs (1) and (4) and sections 1814(a)(2)(C) and 1835(a)(2)(A), nursing care and home health aide services shall be considered to be provided or needed on an "intermittent" basis if they are provided or needed less than 7 days each week and, in the case they are provided or needed for 7 days each week, if they are provided or needed for an initial period of up to 35 consecutive days and for a subsequent period based on a physician certification of exceptional circumstances requiring such services on such a basis.*

* * * * * * *

Reasonable Cost

(v)(1)(A) * * *

* * * * * * *

(G)(i) In any case in which a hospital provides inpatient services to an individual that would constitute [post-hospital] extended care services if provided by a skilled nursing facility and a quality control and peer review organization (or, in the absence of such a qualified organization, the Secretary or such agent as the Secretary may designate) determines that inpatient hospital services for the individual are not medically necessary but post-hospital extended care services for the individual are medically necessary and such

extended care services are not otherwise available to the individual (as determined in accordance with criteria established by the Secretary) at the time of such determination, payment for such services provided to the individual shall continue to be made under this title at the payment rate described in clause (ii) during the period in which—

(I) such [post-hospital] extended care services for the individual are medically necessary and not otherwise available to the individual (as so determined),

(II) inpatient hospital services for the individual are not medically necessary, and

(III) the individual is entitled to have payment made for [post-hospital] extended care services under this title,

except that if the Secretary determines that there is not an excess of hospital beds in such hospital and (subject to clause (iv)) there is not an excess of hospital beds in the area of such hospital, such payment shall be made (during such period) on the basis of the amount otherwise payable under part A with respect to inpatient hospital services.

* * * * * * *

(2)(A) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or [post-hospital] extended care services is in accommodations more expensive than semi-private accommodations, the amount taken into account for purposes of payment under this title with respect to such services may not exceed the amount that would be taken into account with respect to such services if furnished in such semi-private accommodations unless the more expensive accommodations were required for medical reasons.

* * * * * * *

(3) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or [post-hospital] extended care services is in accommodations other than, but not more expensive than, semi-private accommodations and the use of such other accommodations rather than semi-private accommodations was neither at the request of the patient nor for a reason which the Secretary determines is consistent with the purposes of this title, the amount of the payment with respect to such bed and board under part A shall be the amount otherwise payable under this title for such bed and board furnished in semi-private accommodations minus the difference between the charge customarily made by the hospital or skilled nursing facility for bed and board in semi-private accommodations and the charge customarily made by it for bed and board in the accommodations furnished.

* * * * * * *

[Post-Hospital] Extended Care in Christian Science Skilled Nursing Facilities

(y)(1) The term "skilled nursing facility" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only [(except for purposes of subsection (a)(2))] with respect to items and services ordinarily furnished by such an institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations.

(2) Notwithstanding any other provision of this title, payment under part A may not be made for services furnished an individual in a skilled nursing facility to which paragraph (1) applies unless such individual elects, in accordance with regulations, for a [spell of illness] *year* to have such services treated as [post-hospital] extended care services for purposes of such part; and payment under part A may not be made for [post-hospital] extended care services—

(A) furnished an individual during such [spell of illness] *year* in a skilled nursing facility to which paragraph (1) applies after—

(i) such services have been furnished to him in such a facility for 30 days during such [spell] *year,* or

(ii) such services have been furnished to him during such [spell] *year* in a skilled nursing facility to which such paragraph does not apply; or

(B) furnished an individual during such [spell of illness] *year* in a skilled nursing facility to which paragraph (1) does not apply after such services have been furnished to him during such [spell] *year* in a skilled nursing facility to which such paragraph applies.

(3) The amount payable under part A for [post-hospital] extended care services furnished an individual during any [spell of illness] *year* in a skilled nursing facility to which paragraph (1) applies shall be reduced by a coinsurance amount [equal to one-eighth of the inpatient hospital deductible for each day before the 31st day] *equal to the coinsurance amount established under section 1813(a)(3)(C) for each day before the 8th day* on which he is furnished such services in such a facility during such [spell] *year* (and the reduction under this paragraph shall be in lieu of any reduction under section 1813(a)(3)).

[(4) For purposes of subsection (i), the determination of whether services furnished by or in an institution described in paragraph (1) constitute post-hospital extended care services shall be made in accordance with and subject to such conditions, limitations, and requirements as may be provided in regulations.]

* * * * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) * * *

* * * * * * *

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a)(1), (a)(3), or (a)(4), section 1833(b), or section 1861(y)(3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1833(c)*(1)*, clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section. A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1861(s)(10)(A), with respect to items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion), and with respect to clinical diagnostic laboratory tests for which payment is made under part B or which are durable medical equipment furnished as home health services. *A provider of services may not impose a charge under the first sentence of this subparagraph for services for which payment is made to the provider pursuant to section 1833(f) (relating to catastrophic benefits).*

* * * * * * *

(b) An agreement with the Secretary under this section may be terminated—

(1) * * *

* * * * * * *

(3) in the case of inpatient hospital services (including inpatient psychiatric hospital services) or [post-hospital] extended care services, with respect to services furnished after the effective date of such termination, except that payment may be made for up to thirty days with respect to inpatient institutional services furnished to any eligible individual who was admitted to such institution prior to the effective date of such termination.

* * * * * * *

(d) If the Secretary finds that there is a substantial failure to make timely review in accordance with section 1861(k) of long-stay cases in a hospital or skilled nursing facility, he may, in lieu of terminating his agreement with such hospital or facility, decide that, with respect to any individual admitted to such hospital or facility after a subsequent date specified by him, no payment shall be

made under this title for inpatient hospital services (including inpatient psychiatric hospital services) after the 20th day of a continuous period of such services or for [post-hospital] extended care services after such day of a continuous period of such care as is prescribed in or pursuant to regulations, as the case may be. Such decision may be made effective only after such notice to the hospital, or (in the case of a skilled nursing facility) to the facility and the hospital or hospitals with which it has a transfer agreement, and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the Secretary finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur. The Secretary shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

* * * * * * *

VOLUNTARY CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES

SEC. 1882. (a) * * *
(b)(1) * * *

* * * * * * *

(3) Notwithstanding paragraph (1), in the case of a medicare supplemental policy offered in a State and in effect on January 1, 1988, the policy shall not be deemed to meet the standards and requirements set forth in subsection (c), unless each individual who is entitled to benefits under this title and is a policyholder under such policy on January 1, 1988, is sent a letter by not later than January 31, 1988, that explains—

(A) the improved benefits under this title contained in legislation enacted by the first session of the 100th Congress, and

(B) how these improvements affect the benefits contained in the policies and the premium for the policy.

(4) Notwithstanding paragraph (1), a medicare supplemental policy offered in a State shall not be deemed to meet the standards and requirements set forth in subsection (c), with respect to a advertisement (whether through written, radio, or television medium) used (or, at a State's option, to be used) for the policy in the State, unless the entity issuing the policy provides a copy of each advertisement to the Commissioner of Insurance (or comparable officer identified by the Secretary) of that State for his or her review in accordance with State law.

* * * * * * *

HOSPITAL PROVIDERS OF EXTENDED CARE SERVICES

SEC. 1883. (a) * * *

* * * * * * *

(d) Any agreement with a hospital under this section shall provide that payment for services will be made only for services for which payment would be made as [post-hospital] extended care services if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1866; and any

individual who is furnished services, for which payment may be made under an agreement under this section, shall, for purposes of this title (other than this section), be deemed to have received [post-hospital] extended care services in like manner and to the same extent as if the services furnished to him had been [post-hospital] extended care services furnished by a skilled nursing facility under an agreement under section 1866.

* * * * * * *

(f) A hospital which enters into an agreement with the Secretary under this section shall be required to meet those conditions applicable to skilled nursing facilities relating to discharge planning and the social services function (and staffing requirements to satisfy it) which are promulgated by the Secretary under section 1861(j)(15). Services furnished by such a hospital which would otherwise constitute [post-hospital] extended care services if furnished by a skilled nursing facility shall be subject to the same requirements applicable to such services when furnished by a skilled nursing facility except for those requirements the Secretary determines are inappropriate in the case of these services being furnished by a hospital under this section.

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INTERNAL REVENUE CODE OF 1986

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SUBTITLE A—INCOME TAXES

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CHAPTER 1—NORMAL TAXES AND SURTAXES

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Subchapter A—Determination of Tax Liability

Part I. Tax on individuals.

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Part VIII. Supplemental medicare premium.

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PART VIII—SUPPLEMENTAL MEDICARE PREMIUM

Sec. 59B. Imposition of supplemental medicare premium.

SEC. 59B. IMPOSITION OF SUPPLEMENTAL MEDICARE PREMIUM.

(a) IMPOSITION OF PREMIUM.—In the case of a medicare-eligible individual, there is hereby imposed (in addition to any other amount imposed by this subtitle) for each taxable year a premium equal to the annual premium for such year determined under subsection (b).

(b) DETERMINATION OF AMOUNT.—For purposes of this section—

(1) IN GENERAL.—Except as otherwise provided in this subsection—

If the adjusted gross income for the taxable year is:		*The annual premium for the taxable year is:*
Over:	*But not over:*	
$0	$6,000	$0
6,000	6,143	10
6,143	6,287	20
6,287	6,430	30
6,430	6,573	40
6,573	6,716	50
6,716	6,860	60
6,860	7,003	70
7,003	7,146	80
7,146	7,289	90
7,289	7,433	100
7,433	7,576	110
7,576	7,719	120
7,719	7,862	130
7,862	8,006	140
8,006	8,149	150
8,149	8,292	160
8,292	8,436	170
8,436	8,579	180
8,579	8,722	190
8,722	8,865	200
8,865	9,009	210
9,009	9,152	220
9,152	9,295	230
9,295	9,438	240
9,438	9,582	250
9,582	9,725	260
9,725	9,868	270
9,868	10,011	280
10,011	10,155	290
10,155	10,298	300
10,298	10,441	310
10,441	10,585	320
10,585	10,728	330
10,728	10,871	340
10,871	11,014	350
11,014	11,158	360
11,158	11,301	370
11,301	11,444	380
11,444	11,587	390
11,587	11,731	400
11,731	11,874	410
11,874	12,017	420
12,017	12,160	430
12,160	12,304	440
12,304	12,447	450
12,447	12,590	460
12,590	12,734	470
12,734	12,877	480
12,877	13,020	490
13,020	13,163	500
13,163	13,307	510
13,307	13,450	520
13,450	13,593	530
13,593	13,736	540
13,736	13,880	550
13,880	14,023	560
14,023	14,166	570
14,166		580.

(2) SPECIAL RULE WHERE INDIVIDUAL NOT ELIGIBLE FOR ENTIRE TAXABLE YEAR; SHORT TAXABLE YEARS.—If an individual is not a medicare-eligible individual for each month during his taxable year, the annual premium determined under this subsection shall be an amount which bears the same ratio to the amount determined under paragraph (1) as—

(A) the number of months during the taxable year for which such individual is a medicare-eligible individual, bears to

(B) 12.

A similar rule shall apply in the case of a taxable year of less than 12 months; except that adjusted gross income for the taxable year shall be annualized.

(3) SPECIAL RULE FOR JOINT RETURNS.—In the case of a joint return—

(A) this section shall be applied separately with respect to each spouse, and

(B) the adjusted gross income of each spouse shall be ½ of their combined adjusted gross income.

(4) ADJUSTMENTS TO TABLE.—

(A) IN GENERAL.—Not later than December 15 of 1988 and each subsequent calendar year, the Secretary shall prescribe a table which shall apply in lieu of the table contained in paragraph (1) with respect to taxable years beginning in the succeeding calendar year.

(B) METHOD OF PRESCRIBING TABLE.—The table which, under subparagraph (A), is to apply in lieu of the table contained in paragraph (1) with respect to taxable years beginning in any calendar year shall be prescribed—

(i) by increasing each dollar amount setting forth the amount of the premium in such table by the medicare inflation factor for such calendar year, and

(ii) by increasing each other dollar amount in such table by the cost-of-living adjustment for such calendar year (as defined in section 1(f)(3)).

(C) MEDICARE INFLATION FACTOR.—For purposes of subparagraph (B), the medicare inflation factor for any calendar year is the percentage (if any) by which—

(i) the medicare value for such calendar year, exceeds

(ii) the medicare value for 1988.

(D) ROUNDING.—If any increase determined under subparagraph (B) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

(c) DEFINITIONS AND SPECIAL RULES.—

(1) MEDICARE-ELIGIBLE INDIVIDUAL.—For purposes of this section—

(A) IN GENERAL.—Except as otherwise provided in this paragraph, the term "medicare-eligible individual" means, with respect to any month, any individual who is entitled to (or, on application without the payment of an additional premium, would be entitled to) benefits under part A of title XVIII of the Social Security Act for such month.

(B) EXCEPTIONS.—The term "medicare-eligible individual" shall not include for any month—

(i) any individual who is entitled to benefits under part A of title XVIII of the Social Security Act for such month solely by reason of the payment of a premium under section 1818 of such Act,

(ii) any individual who is required to pay a premium for such month increased or computed under paragraph (4) or (5) of section 1839(e) of the Social Security Act, or

(iii) any qualified nonresident.

(C) TREATMENT OF INDIVIDUALS WHO HAVE ATTAINED AGE 65.—An individual (other than a nonresident alien) who has attained age 65 shall be treated as a medicare-eligible individual for the month in which he attains age 65 and any subsequent month unless such individual establishes to the satisfaction of the Secretary that he is not a medicare-eligible individual for the month concerned.

(2) MEDICARE VALUE.—

(A) IN GENERAL.—For purposes of this section, the term "medicare value" means, for any calendar year, the sum of the Medicare part A value for January of such calendar year and the Medicare part B value for January of such calender year.

(B) MEDICARE PART OF VALUE.—For purposes of subparagraph (A), the term "Medicare part A value" means, with respect to any month, an amount equal to 50 percent of the monthly actuarial rate promulgated under section 1818(d)(1) of the Social Security Act for such month.

(C) MEDICARE PART B VALUE.—for purposes of subparagraph (A), the term "Medicare part B value" means, with respect to any month, an amount equal to the excess of—

(i) the amount equal to twice the monthly actuarial rate established under section 1839(a)(1) of the Social Security Act for the calendar year which includes such month, over

(ii) the amount of the monthly premium for such month established under section 1839 of such Act (without regard to subsections (b), (e)(4), (e)(5), and (f) thereof).

(3) QUALIFIED NONRESIDENT.—

(A) IN GENERAL.—For purposes of paragraph (1), the term "qualified nonresident" means, with respect to any month during the taxable year, any individual if—

(i) such individual is not furnished during such taxable year or any of the 4 preceding taxable years any service for which a claim for payment is or will be made under part A of title XVIII of the Social Security Act,

(ii) such individual is not entitled to benefits under part B of title XVIII of the Social Security Act at any time during such taxable year or any of the 4 preceding taxable years; and

(iii) such individual is present in a foreign country or countries for at least 330 full days during—

(I) the 12-month period ending at the close of the taxable year, and

(II) each of the 4 consecutive preceding 12-month periods.

(B) SPECIAL RULE FOR INDIVIDUALS WHO DIE DURING THE TAXABLE YEAR.—An individual who dies during the taxable year shall be treated as meeting the requirements of subparagraph (A)(iii)(I) if such individual is present in a foreign country or countries is present in a foreign country or countries for at least a number of full days equal to 90 percent of the days during such taxable year before the date of death.

(4) COORDINATION WITH OTHER PROVISIONS.—

(A) NOT TREATED AS MEDICAL EXPENSE.—The premium imposed by this section shall not be treated as an expense paid for medical care for purposes of section 213.

(B) NOT TREATED AS TAX FOR CERTAIN PURPOSES.—The premium imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

(i) the amount of any credit allowable under this chapter, or

(ii) the amount of the minimum tax imposed by section 55.

(C) TREATED AS TAX FOR SUBTITLE F.—For purposes of subtitle F, the premium imposed by this section shall be treated as if it were a tax imposed by section 1.

(D) SECTION 15 NOT TO APPLY.—Section 15 shall not apply to the premium imposed by this section.

* * * * * * *

Subtitle F—Procedure and Administration

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CHAPTER 61—INFORMATION AND RETURNS

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Subchapter A—Returns and Records

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PART II—INFORMATION RETURNS

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Subpart B—Information Concerning Transactions With Other Persons

Sec. 6041. Information at source.

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Sec. 6050O. Returns relating to individuals entitled to receive benefits under Medicare part A.

* * * * * * *

SEC. 6050O. RETURNS RELATING TO INDIVIDUALS ENTITLED TO RECEIVE BENEFITS UNDER MEDICARE PART A.

The Secretary of Health and Human Services shall make a return (at such times and in such form as the Secretary may prescribe) setting forth the name, address, and TIN of each individual who is entitled to receive benefits (other than by reason of the payment of a premium referred to in clause (i) or (ii) of section 59B(c)(1)(B)) under part A of title XVIII of the Social Security Act for any month during the calendar year and the number of months in the calendar year for which the individual is so entitled.

* * * * * * *

SECTION 2355 OF THE DEFICIT REDUCTION ACT OF 1984

WAIVERS FOR SOCIAL HEALTH MAINTENANCE ORGANIZATIONS

SEC. 2355. (a) * * *

(b) A project referred to in subsection (a) is a project—

(1) * * *

* * * * * * *

(5) under which all payors will share risk for no more than two years, with the organization being at full risk in the third year *and in succeeding years;*

* * * * * * *

(d)(1) The Secretary of Health and Human Service shall submit a preliminary report to the Congress on the status of the projects and waivers referred to in subsection (a) 45 days after the date of the enactment of this Act.

(2) The Secretary shall submit a **[**final**]** *interim* report to the Congress on the projects referred to in subsection (a) not later than 42 months after the date of the enactment of this Act.

VI. ADDITIONAL VIEWS

ADDITIONAL VIEWS OF THE HONORABLE BILL FRENZEL

When I first heard of the President's proposal to provide catastrophic health insurance as a part of Medicare, I thought it was a wonderful idea. I still do. However, subcommittee changes to the original concept have produced a bill that may not live up to the original promises.

As submitted by the President, the bill was tight and its financing was simple. The concept was reasonably clean. Young persons were not being forced to finance health care for their elders.

The Health subcommittee and the full Committee made a number of important changes. The most obvious ones were in financing. Instead of the flat across-the-broad premium, the finance plan included both an across-the-board premium (Part B premium adjustment of $1.00 in 1990 rising to $1.50 in 1992) and a mandatory supplemental premium ranging from $1.18 to $70.00 per month based on income.

Because of anxieties expressed in the full Committee the variable financing element was described as a supplemental premium rather than a taxable actuarial value. The concept of the "premium" is substantially similar to "the taxable actuarial value."

For me, the financing is not the biggest problem. Either a flat premium or a variable income-based fee is acceptable. Actually, I prefer the income-based approach as a first step toward means-testing the Medicare program.

The benefit section, however, poses some real risks. One fact from the subcommittee background materials pamphlet (pg. 67) illustrates the problem. In the five-year period covered by the CBO estimates, the President's benefit package would have cost about $13 billion. The subcommittee's proposal costs about twice as much, $24 billion.

That is the general dimension of the problem. However, the most frightening aspect of the bill is the cost/revenue relationship in the years beyond 1992. The Department of Health and Human Services says that costs will exceed revenues in the period after 1992. CBO, with its usual uselessness, says only that it has no estimates after 1992.

HHS estimates annual deficits of $10 billion by 2000, and $30 billion by 2005. If those figures are anywhere near right, the result will be a raid on the Medicare Trust Fund or unacceptable premiums for older Americans. Either alternative is enough to give any sober Congressman pause.

The bill fills a needed gap in Medicare policy. Something like it is needed. Clearly some sort of legislation is called for.

This bill has a long way to go. It would be premature to stop it now. But it is appropriate to raise questions now, and demand answers now, and seek ways to reduce what seem to be unacceptable risks.

BILL FRENZEL.

ADDITIONAL VIEWS OF THE HONORABLE BRIAN DONNELLY TO ACCOMPANY H.R. 2470

The Committee on Ways and Means deserves credit for its efforts in drafting this legislation, the first major expansion of the Medicare program since its enactment in 1965. Unfortunately, I can only provide reluctant support for this measure. It is may belief that the legislation promises more than it delivers, and I have great concerns over two areas which the legislation does not address.

NON-ASSIGNED CLAIMS UNDER MEDICARE

The legislation's noble intent is to limit beneficiary out-of-pocket expenses for Part B services to $1,043 per year. The reality, of course, is that the legislation does not limit beneficiary expenses to the extent that the beneficiary's physician does not accept assignment. Thus, beneficiaries in all but one state [1] still can and will face "catastrophic" medical expenses even after H.R. 2470 is fully implemented.

Realistically, there is no reason that physicians should be allowed to balance bill Medicare beneficiaries who have incurred $1,043 in Part B expenses. Physician reimbursement under Medicare is determined on the basis of actual, customary and prevailing charges: standards determined by the physicians themselves.

Unfortunately, the Committee defeated an amendment I offered which would have mandated that all Medicare claims be assigned once a beneficiary had exceeded the Part B cap of $1,043 established in the legislation. According to the Congressional Budget Office, my amendment would have saved beneficiaries $938 million in calendar year 1988, a number which clearly demonstrates how pervasive the problem of balance billing is.

I recognize that the entire issue of physician reimbursement under Medicare is extremely controversial, and the Committee on Ways and Means will be closely examining those issues later this year. I felt—and still feel—that the only way to rein in health care costs is to impose some type of assignment requirement on physicians, and I will continue to pursue this issue further.

LONG-TERM CARE

Another area where the Committee bill falls short in addressing the true needs of the elderly is in the area of long-term care. The true catastrophic expenses for senior citizens come from custodial nursing home care. Yet Medicare reimburses only a miniscule portion of the costs for this care: much to the shock of many Medicare

[1] Massachusetts has enacted legislation prohibiting physicians from "balance billing" their patients. The law, which was the subject of numerous constitutional challenges, was recently upheld by the First Circuit Court of Appeals.

beneficiaries. Very few private insurance companies offer such coverage.

In this bill, the Committee missed an important opportunity to address these concerns of the elderly. The longer we wait, the more acute the problem will become. Senior citizens, generally, face catastrophic medical expenses when they are forced to go into a nursing home, not when they are hospitalized. No amount of planning and foresight on their part can prepare them for the costs they face in a nursing home. Rather, beneficiaries "spend down" their life savings and force Medicaid to pay for their care. Certainly, we have the ability to deal with senior citizens in a more humane manner.

The Committee rejected a modest amendment I offered dealing with long-term care which would have expanded the enormously successful S/HMO concept pioneered by Brandeis University. Although the Committee did agree to reauthorize the four existing S/HMOs, I would have preferred to see much larger demonstration projects. Fortunately, the Committee did agree with me on the need for research into long-term care, and authorized $5 million for each of the next five years for this research.

In conclusion, it is with reluctance that I support H.R. 2470. I believe that the Committee could and should have gone further in the areas I have mentioned, and hope that these issues are addressed on the floor of the House or by the Senate.

BRIAN DONNELLY.

VII. DISSENTING VIEWS OF THE HONORABLE BILL ARCHER, PHILIP M. CRANE, RICHARD T. SCHULZE, HAL DAUB, JUDD GREGG, AND HANK BROWN

The original goal of the Committee on Ways & Means regarding Medicare catastrophic protection legislation was a noble one: to protect the elderly from the threat of financial ruin resulting from a devastating and prolonged illness. The thousands of elderly individuals who face impoverishment as a result of high hospital and other medical costs are of great concern to many of us. We believe, however, that while the problem of catastrophic health expenses warrants a solution, the alternative reported by the Committee (H.R. 2470, "The Medicare Catastrophic Protection Act of 1987") jeopardizes the financial viability of the Medicare program itself.

We are genuinely disappointed at the lack of actuarial information available to the Committee about how this expansion of the Medicare program will strain the already troubled Medicare trust fund. Many of us are disappointed that the Committee reported bill remains silent on the more probable catastrophic costs faced by the elderly, those of long-term care, such as prolonged stays in nursing homes. Furthermore, a number of us are wary of any Medicare program expansion not containing adequate safeguards to prevent the type of over-utilization that might threaten the program's collapse. In addition, a number of us are deeply concerned that this new entitlement program will eliminate much of the retirement health insurance market. Further, the proposal does not seek ways to expand the private sector's involvement in insuring those elderly individuals who face an acute catastrophic illness against financial ruin.

When evaluating the Committee acute care proposal, one might do well to remember the guidelines set forth by the President for his intitiative on Catastrophic Illness Insurance for the elderly. These guidelines were enumerated in the press release issued immediately following his 1987 State of the Union Address. The guidelines are as follows:

> We must provide meaningful protection against out-of-pocket expenses that substantially threaten family savings;
>
> The importance of Medicare, Medicaid and Medigap should be maintained and we should not encourage excessive use of services;
>
> Any catastrophic illness coverage should be voluntary, not a new government entitlement; and
>
> The proposal must be fully budget-netural, without the explosive potential of program expansions.

Several of us had hoped that the Committee would follow these guidelines in the design of the Committee bills so as to create a constructive and positive solution to the problem posed to the Committee. But even a cursory glance at the summary of this bill

shows us that the Committee's expansion of the Medicare program meets very few, if any, of the President's guidelines. Many of us feel that a number of the provisions of the bills directly conflict with these guidelines.

When dealing with any type of modifications or expansion of the Medicare program, Congress must be keenly aware of the prediction in the 1987 report of the Medicare trustees that, under alternative II-B assumptions, the trust funds would be exhausted by the year 2002. Any expansion of the benefits offered by the Medicare program should be budget neutral in both the near and distant future. However, many of us are genuinely skeptical that the Committee has taken proper precautions to ensure that this new entitlement program, along with its many well-intended expansions of current Medicare benefits, will not create large deficits in future years. Should deficits occur, this program will only quicken the arrival of the impending Medicare financial crisis, thus threatening the future availability of the very core of benefits already offered under the Medicare program.

While few of us dispute that this bill does provide meaningful protection for out-of-pocket expenses, as called for in the first of the President's guidelines, several of us would like to point out that a number of the elderly might be misled to believe that all out-of-pocket costs of illness, whether for acute or long-term medical care, above the cap of approximately $1700, are covered. The title of the bill "The Medicare Catastrophic Protection Act of 1987," is certainly a misnomer. Even with the expanding the program, Medicare still does not cover many medical bills that can be substantial. For example, such costly expenses may include physician fees beyond Medicare-approved charges, dental care, prescription eyeglasses, and outpatient prescription drugs. More important, the bill does not address the issue of expenses for long-term care, which can be truly catastrophic and often represent the greatest fears for the elderly. Clearly, the bill is misleading, as it gives the elderly the impression that nursing home or other extended care services will now be covered by Medicare.

Several of us are also distressed to see that this bill seems to conflict directly with the President's guideline that the importance of medigap insurance be maintained. Instead of encouraging greater use of the private sector, the proposed Medicare catastrophic program replaces, and would even discourage, the Medicare supplemental insurance market in the private sector. Nearly 70 percent of Medicare's 28.4 million beneficiaries currently purchase supplemental policies (medigap insurance), many of which provide coverage for health care costs similar to or better than the expanded entitlement program in the Committee's bill. Given that another eight percent of beneficiaries are also eligible for Medicaid, which assists low-income elderly by meeting virtually all of their acute care health costs, there remain only five million beneficiaries who are currently without medigap or Medicaid coverage. Of these five million beneficiaries, fewer than 12,000 can expect to incure hospital stays longer than the 150 day limit currently contained in the Medicare program.

This leads to a critical question which a number of us feel was insufficiently discussed by the Committee: Should the government

be spending an additional five billion dollars a year to provide for so few of Medicare's beneficiaries?

Several of us feel that the Medicare catastrophic proposal contained in H.R. 2470 undermines the Medigap market by eliminating the most insurable risks from the market. At the same time, many of us feel that it is not likely that the Medigap insurers then will cover those expenses not covered in the proposals, such as drugs, eyeglasses, dental, or other services, which neither Medigap policies nor Medicare now cover.

In addition, a number of us would like to point out that four to five million Americans now have comprehensive medical coverage, with both Medicare and retiree health "benefits" from their employers. Many of them do not currently pay even Part B premiums. While these Medicare beneficiaries will receive no enhanced coverage from the Committee proposal, those elderly with taxable income, under the financing mechanism, will be forced to pay surtaxes for benefits for which they already have paid through private insurance coverage. The result will be greater reliance on the government benefits as these elderly accept enhanced Part B coverage for which they would now mostly be paying in the form of surtaxes.

The second of the President's guidelines also cautions that "we should not encourage excessive use of services." However, many of us are quite skeptical whether this bill contains adequate safeguards to prevent over-utilization. One need look only at the projected growth rates of the expansion of benefits beyond the acute care provision to see the huge potential for over-utilization. Over the first five years of the expansion of benefits, spending on the new mental health benefit will grow 55%, spending on the new home health benefit will increase 76%, and spending on the new skilled nursing facility benefit will increase 136%. In addition, many of us feel that the Part B cap of $1,000 will add "fuel to the fire" of the fastest growing segment of the Medicare program, physician payment. If Medicare begins to pay 100% of the allowed charges after the first $1,000, SMI trust fund expenditures could grow even more rapidly than the current 15.3% growth this year and 30% growth projected over the past four years. About 2.5% of the increase in physician payments is due to a higher than expected volume in services, a phenomenon unexplained by the expanding population of Medicare beneficiaries. Many of us feel that the low cap likely will add an incentive to provide even more tests and procedures.

In regard to the third guideline set by the President, that "any catastrophic illness coverage should be voluntary, not a new government entitlement," many of us feel that provisions in the Committee reported bill are clearly new entitlements. H.R. 2470 entitles all Medicare beneficiaries to unlimited inpatient hospital stays, expands the current entitlement of 100 days of skilled nursing facility care per spell of illness to 150 days per year, and expands the current entitlement for hospice care. While the bill provides Medicare catastrophic coverage for those persons voluntarily enrolling in Part B, many of us would like to note that this bill does not give those individuals who enroll in Part B (about 97% of Medicare beneficiaries) the option of accepting this additional coverage.

Thus, for those enrolled in Part B, but covered by private insurance for acute catastrophic expenses (about 65.4% of the elderly), this can be seen as an unnecessary new entitlement program. Furthermore, it is disturbing to several of us to find that the financing mechanism, in that it levies a surtax on all the elderly who have taxable income, forces those individuals who do not enroll in Part B, but who have taxable income, to pay for the benefits which they will never receive.

As concerns the fourth and final guideline of the President, that the proposal remain fully budget-neutral, many of us feel that the bill threatens to be a budget buster. As stated earlier, we are concerned with the lack of actuarial estimates available to the Committee as to whether or not the acute care benefit will be budget neutral beyond the first five years of the program.

During the Committee mark-up, the Health Care Financing Administration actuary testified that, given the original financing proposal (including in taxable income the actuarial value of the Part A and Part B benefits), the new program would have a $10 billion revenue shortfall in the year 2000, worsening to a $30 billion revenue shortfall by the year 2005. Given the currently projected depletion date of the Medicare Trust Funds (2002, under the Medicare Trustee's intermediate economic assumptions), these figures certainly cause many of us to question whether the Committee has taken the proper safeguards to prevent this expansion of the Medicare program from threatening the program's very existence. While the Subcommittee-reported financing was replaced by a premium and surtax formula, we do not believe that there has been adequate evidence available to show that this new funding method will ensure that this new entitlement program will remain budget neutral. Preliminary estimates by the Department of Treasury, using the Medicare actuaries' alternative II–B assumptions, show that the average cost per Medicare enrollee of the Committee's proposal is approximately $150 per enrollee in 1989. By the year 2005, if the program is to remain budget neutral, this average cost will have grown to be somewhere between $800 to $1000 per enrollee, and this is in 1988 dollars! In addition, the Treasury Department estimates that, by the year 2005, the $1700 cap on out-of-pocket costs will have risen to between $3000 and $4000, again in 1988 dollars. Furthermore, the Treasury Department estimates that this program, which in 1989 will represent about 5% of the Medicare program costs, will grow to be about 10% of the Medicare program in the year 2005. Certainly, these figures warrant a far greater consideration of the long-term potential for explosive costs than the few minutes which was given by the Committee.

It is clear to us that the Committee proposal conflicts with many of the guidelines set by the President for the catastrophic illness insurance program. We do not wish to see an expansion of Medicare which theatens the very financial security of the system itself. We also do not wish to see a bill which misleads the elderly into believing that all their retirement health needs beyond an out-of-pocket cap will be taken care of by the national government. In addition, we certainly question the wisdom of replacing the private insurance market with a new federal government program. Furthermore, we are opposed to the involuntary nature of this pro-

gram. Also, we are quite wary of the projected increases of the mandatory progressive surtaxes levied upon certain sectors of the elderly population. For the reasons cited here and many more, we cannot support H.R. 2470, as reported by the Committee on Ways and Means, in its current form.

BILL ARCHER.
HAL DAUB
HANK BROWN.
PHIL CRANE.
RICHARD SCHULZE.
JUDD GREGG.

VIII. ADDITIONAL DISSENTING VIEWS

ADDITIONAL DISSENTING VIEWS OF THE HONORABLE HAL DAUB

The time has certainly come for Congress to reexamine the Medicare Program and to address the changing needs of our Nation's senior citizens. Efforts to provide protection against catastrophic health care costs are commendable; however, I am concerned that the committee's bill, H.R. 2470, "The Medicare Catastrophic Protection Act of 1987," will perpetuate the myth among many of the elderly that Medicare covers all the costs of illness, whether acute medical or longterm care expenses. The title of the bill is certainly a misnomer. The legislation does not "close" all of the gaps that now exist in Medicare coverage.

My greatest concern is that H.R. 2470 fails to protect the elderly sufficiently against what I believe to be the most devastating catastrophic expenses—namely, those associated with longterm care. In testimony before the Ways and Means Health Subcommittee, representatives of various senior groups have attested to the fact that the greatest deficiency in the present health care system is the lack of a longterm care system encompassing medical, social, and personal care services provided in a variety of community, home-based, and non-institutional settings.

I have authored legislation, H.R. 1776, "The Longterm Health Care Amendments of 1987," which addresses these critical issues now facing our elderly population, and which offers incentives for the working-age population so that they may begin to provide for their future health care needs.

My legislation incorporates a balance of governmental, individual, and employer incentives that begin to build those reserves that will be necessary to adequately fund any longterm care program. There is no doubt that the provision of longterm care benefits—whether it be through a government program or via the establishment of individual insurance incentives—will be a costly proposition. Considering, though, that the committee's bill, H.R. 2470, will expend $25 billion over the next five years, I strongly believe that these funds would be more appropriately spent in the longterm care area.

The definition of "catastrophic illness" alone can be interpreted in many ways, depending upon where one sees the greatest demand for need. I am convinced that our senior citizen's catastrophic costs arise from those costs associated with longterm care.

The committee had a real opportunity to address some very critical health policy issues, but missed the mark. I cannot support H.R. 2470 in its present form.

HAL DAUB.

ADDITIONAL DISSENTING VIEWS OF THE HONORABLE JUDD GREGG

Clearly, the time has come to consider Medicare coverage for catastrophic illness. No one should have to live with the fear that a long hospital stay could drain a lifetime of savings. The question before Congress, then, is not whether we should reevaluate the adequacy of the current Medicare benefit but, more appropriately: HOW should we approach this challenge? The Committee on Ways and Means was presented with two basic approaches to the issue of Medicare coverage for catastrophic illness: H.R. 2470, the Stark-Gradison "Catastrophic Protection Act of 1987" and H.R. 1245, President Reagan's initiative, "The Medicare Catastrophic Illness Coverage Act." In approving H.R. 2470 and rejecting H.R. 1245, the Committee has issued a shortsighted and fiscally unsound response to the long-range health care needs of our senior citizens.

The President's initiative, H.R. 1245, makes some much-needed changes in the Medicare system, is actuarially sound and costs one-half the price of H.R. 2470. Consequently, it is a much more appropriate and fiscally responsible approach to the issue of Medicare coverage for catastrophic illness. Furthermore, H.R. 1245 does not contain many of the serious policy implications found in H.R. 2470. First, actuaries at the Department of Health and Human Services project that the Stark-Gradison benefits package could drain the Medicare Trust Funds by as much as $10 billion in the year 2000, and $30 billion in the year 2005. Using moderate economic forecasts, we can expect the Hospital Insurance Trust Fund to run deficits of $1.6 billion as early as 1995. By the year 2002, the fund will be insolvent and will have deficits of as much as $32 billion. Paying for current benefits will be difficult enough given the problems of an already grossly underfunded program. H.R. 2470 will make a bad situation much worse; H.R. 1245 will not.

A second problem with the Stark-Gradison plan is the fact that, to a great extent, what is being delivered is a replacement of private insurance. Today, 70% of senior citizens are covered for high out-of-pocket expenses by Medicare supplemental policies. Medicaid provides coverage for another 10% of the population over 65. In an HIAA survey of top commercial Medigap policies, 86% of insureds were covered for 100% of all Medicare allowable hospital expenses, 92% were covered for the Part A hospital deductible and 93% had unlimited coverage for Medicare allowable Part B expenses. Stark-Gradison, then, at a cost of $24 billion, gives additional coverage to only a small percentage of people, while essentially socializing an entire area of health care that is now being satisfactorily handled by the private sector. Scarce federal resources are being misapplied and, rather than encouraging the private sector to bear some of the costs of the insurance, we are actually replacing private dollars with federal tax dollars.

Third, one must wonder at the arbitrary and unrealistic definition of "catastrophic cost" imposed by Stark-Gradison. Clearly, there is a need for insurance coverage, in some cases even federal coverage, for extremely expensive health care services, where private sector activity is insufficient. But is $1500 truly catastrophic, particularly in view of the fact that many low-income seniors qualify for Medicaid which offsets a large portion of the $1500? If we are to consider $1500 in health care costs to be catastrophic, how do we view the $4410 spent annually by the average elderly household for shelter or the $2372 food cost and $2246 transportation cost encountered each year by the average senior citizen? Why Congress is so rigid in adhering to an arbitrary definition of "catastrophic" when the costs are so high and the benefits so misdirected is incomprehensible.

In truth, H.R. 1245, not H.R. 2470, is the best approach to Medicare coverage for catastrophic illness. The President's initiative accomplishes a worthy goal of restructuring the current Medicare acute care benefit, and is a clear and definite improvement over the present system. It does not contain benefits that will raid the already fragile Medicare Trust Funds or sprial in the out-years. Unlike H.R. 2470, which indexes its catastrophic cap to the Social Security COLA, H.R. 1245 indexes its cap to Medicare inflation, thus guaranteering costs to increase at a slower, more predictable pace. H.R. 1245, at a five-year cost of $12 billion, provides beneficiaries with added acute care protection but, unlike Strak-Gradison, does not spend $24 billion dollars in the process.

Finally, H.R. 1245 does not raid the pockets of beneficiaries. It does not cut off future revenue sources for other burdensome, often catastrophic, out-of-pocket costs incurred by the elderly: balance billing, dental and eye care, and most importantly, long-term care. Under H.R. 2470, some beneficiaries who are now paying $214.80 annually for their Medicare Part B coverage (which in 1965 was $36 annually) would be required to pay as much as $1,265.000 in 1992, an increase of 590%. It is clearly unfair to make some individuals pay almost six times what they are paying now for a benefit that is very likely already being covered by private Medicare supplemental policies. An income-related supplemental premium approach could easily be applied to H.R. 1245 to require those who can afford to pay more to do so, at generally less cost than under H.R. 2470.

In summary, the major difference between H.R. 1245 and H.R. 2470 is the fact that H.R. 1245 addresses problems and H.R. 2470 creates them. In the frenzy to provide new benefits, few are considering priorities or worrying about uncontrollable costs. The creation of huge deficits in the Medicare Trust Funds in the out-years, the failure to leverage private dollars with federal dollars, and the misguided replacement of private sector involvement with federal programs most certainly should not be the doctrine at the heart of this federal initiative or those to come. It is unfortunate that the Committee could not recognize this and be more receptive to a plan which does not result in a $24 billion dollars catastrophe.

JUDD GREGG.

100TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPT. 100-105
Part 2

MEDICARE CATASTROPHIC PROTECTION ACT OF 1987

JULY 1, 1987.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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Mr. DINGELL, from the Committee on Energy and Commerce, submitted the following

REPORT

together with

DISSENTING VIEWS

[To accompany H.R. 2470 which on May 19, 1987, was referred jointly to the Committee on Ways and Means and the Committee on Energy and Commerce]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 2470) to amend title XVIII of the Social Security Act to provide protection against catastrophic medical expenses under the Medicare Program, and for other purposes, having considered the same, reports favorably thereon with amendments and recommends that the bill as amended do pass.

CONTENTS

	Page
The Amendment	2
Purpose and Summary	35
Background and Need for Legislation	37
Explanation of Legislation	38
Provisions Relating to Part A of Medicare	38
Inpatient hospital services	38
Extended care services	40
Hospice care	40
Blood deductible	41
Home health benefits	41
Imposition of supplemental Medicare premium	42
Provisions Relating to Part B of Medicare and Medicaid	44
Limitation on Medicare out-of-pocket expenses under Part B	44
Coverage of catastrophic expenses for prescription drugs and insulin	46
In-home care for certain chronically dependent individuals	51

Extending home health services 53
Increase in maximum payment allowed for outpatient mental health services 54
Coverage of influenza vaccine and its administration 55
Mailing of notice of Medicare benefits and participating physician directories 56
Requiring Medicaid buy-in of premiums and cost-sharing for poor Medicare beneficiaries 57
Adjustment in Medicare Part B premium 62
Changes in certification of Medicare supplemental health insurance policies 63
Extension of social HMO demonstration project 64
Study on comprehensive medical coverage under the Medicare program 64
Research on long-term care services for Medicare beneficiaries 64
Protection of income and resources of couple for maintenance of community spouse 65
Study of adult day care services 78
Bipartisan Commission on Comprehensive Health Care 79
Hearings 80
Committee Consideration 80
Committee Oversight Findings 80
Committee on Government Operations 80
Committee Cost Estimate 80
Congressional Budget Office Estimate 81
Inflationary Impact Statement 96
Agency Views 96
Changes in Existing Law Made by the Bill, as Reported 98
Dissenting Views 152

The Amendment

The amendments are as follows:

Page 2, the table of contents is amended by striking the items relating to title II and inserting the following:

TITLE II—PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM AND TO THE MEDICAID PROGRAM

Sec. 201. Limitation on medicare out-of-pocket expenses under part B.
Sec. 202. Coverage of catastrophic expenses for prescription drugs and insulin.
Sec. 203. In-home care for certain chronically dependent individuals.
Sec. 204. Extending home health services.
Sec. 205. Increase in maximum payment allowed for outpatient mental health services.
Sec. 206. Coverage of influenza vaccine and its administration.
Sec. 207. Mailing of notice of medicare benefits and participating physician directories.
Sec. 208. Requiring medicaid buy-in of premiums and cost-sharing for poor medicare beneficiaries.
Sec. 209. Adjustment in medicare part b premium.
Sec. 210. Changes in certification of medicare supplemental health insurance policies.
Sec. 211. Extension of social HMO demonstration project.
Sec. 212. Study on comprehensive medical coverage under the medicare program.
Sec. 213. Research on long-term care services for medicare beneficiaries.
Sec. 214. Protection of income and resources of couple for maintenance of community spouse.
Sec. 215. Study of adult day care services.

TITLE III—UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

Sec. 301. Establishment.
Sec. 302. Duties.
Sec. 303. Membership.
Sec. 304. Staff and consultants.
Sec. 305. Powers.

Sec. 306. Report.
Sec. 307. Termination.
Sec. 308. Authorization of appropriations.

Page 27, strike out line 10 and all that follows through page 48, line 6, and insert the following:

TITLE II—PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM AND TO THE MEDICAID PROGRAM

SEC. 201. LIMITATION ON MEDICARE OUT-OF-POCKET EXPENSES UNDER PART B.

(a) IN GENERAL.—Section 1833 (42 U.S.C. 1395l) is amended—

(1) by inserting after subsection (e) the following new subsection:

"(f)(1) Notwithstanding subsections (a) and (b), if an individual has incurred out-of-pocket part B expenses (as defined in paragraph (2)) in a calendar year (beginning with 1989) in an amount equal to the part B catastrophic limit (established under paragraph (3)) for the year, payment under this part with respect to any additional incurred expenses in the calendar year shall be made as if—

"(A) the deduction described in the second sentence of subsection (b) (relating to blood) no longer applied, and

"(B) '100 percent' and '0 percent' were substituted for '80 percent' and '20 percent', respectively, each place either appears in subsection (a), in section 1833(i)(2), in section 1835(b)(2), and in subsections (b)(2) and (b)(3) of section 1881.

"(2) In this subsection, the term 'out-of-pocket part B expenses' means—

"(A) the deductions established under subsection (b), and

"(B) the difference between the payment amount provided under this part and the payment amount that would be provided if '100 percent' and '0 percent' were substituted for '80 percent' and '20 percent', respectively, each place either appears in subsection (a), in section 1833(i)(2), in section 1835(b)(2), and in subsections (b)(2) and (b)(3) of section 1881.

Such term also includes reasonable expenses (as defined by the Secretary) incurred for an annual colorectal examination for cancer and reasonable expenses (as defined by the Secretary) incurred for a mammogram, once every third year, for detection of breast cancer.

"(3)(A) The part B catastrophic limit for 1989 is $1,043. The part B catastrophic limit for any succeeding year shall be an amount equal to the part B catastrophic limit for the preceding year increased by the applicable increase percentage determined under section 215(i) in the previous year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

"(B) Not later than November 15 of each year (beginning with 1988), the Secretary shall promulgate the part B catastrophic limit under this paragraph for the succeeding year.

"(4) In applying paragraph (1) in the case of an organization receiving payment under clause (A) of subsection (a)(1) or under a reasonable cost reimbursement contract under section 1876—

"(A) the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect, in the aggregate, the aggregate increase in payments that would otherwise be made with respect to enrollees in the organization if payments were made other than under such clause or such a contract or with respect to individuals furnished services through the facility if payments were to be made on an individual-by-individual basis, and

"(B) the organization or facility shall provide assurances satisfactory to the Secretary that the organization or facility will not undertake to charge an individual during a year for services for which payment may be made under this part after the individual has incurred (whether through the organization, facility or otherwise) out-of-pocket part B expenses in the year in an amount equal to the part B catastrophic limit established under paragraph (3) for the year."; and

(2) in subsections (c) and (g), by striking "(a) and (b)" each place it appears and inserting "(a), (b), and (f)".

(b) LIMITATION ON CHARGES WHEN CATASTROPHIC LIMIT REACHED.—Section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended by adding at the end the following new sentence: "A provider of services may not impose a charge under the first sentence of this subparagraph for services for which payment is made to the provider pursuant to section 1833(f) (relating to catastrophic benefits).".

(c) ENCOURAGING RESTRAINT ON BALANCE BILLING FOR BENEFICIARIES REACHING CATASTROPHIC LIMIT.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

(1) by striking "and" at the end of subparagraph (G),

(2) by inserting "and" at the end of subparagraph (H), and

(3) by inserting after subparagraph (H) the following new subparagraph:

"(I) if it makes determinations or payments with respect to items and services furnished by a physician for which payment is made pursuant to section 1833(f) but not on an assignment-related basis, provide to the physician a notice that—

"(i) states that the individual provided the service has reached the part B catastrophic limit on out-of-pocket expenses for the year, and

"(ii) encourages the physician not to charge the individual amounts in excess of the reasonable charge recognized under this section and to accept payment on an assignment-related basis for physicians' services furnished the individual during the remainder of the year;".

SEC. 202. COVERAGE OF CATASTROPHIC EXPENSES FOR PRESCRIPTION DRUGS AND INSULIN.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) is amended—

(1) by amending subaragraph (J) of subsection (s)(2) to read as follows:

"(J) covered outpatient drugs (as defined in subsection (t)(2)); and"; and

(2) in subsection (t)—

(A) by striking "subsection (m)(5)" and inserting "subsections (m)(5) and (s)(2)(J) and paragraph (2)",

(B) by inserting "(1)" after "(t)", and

(C) by adding at the end the following new paragraph:

"(2) The term 'covered outpatient drug' means—

"(A) a drug which—

"(i) is approved for safety and effectiveness as a prescription drug under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act, or

"(ii) in the case of a drug which is biological product, is licensed under section 351 of the Public Health Service Act, and

"(B) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act;

but does not include any drug or insulin provided to an inpatient as part of inpatient hospital services (described in subsection (b)(2)), as part of extended care services (described in subsection (h)(5)), or as an incident to physicians' services under subparagraph (A) or (B) of subsection (s)(2).".

(b) DEDUCTIBLE AND PAYMENT AMOUNTS.—

(1) IN GENERAL.—Section 1833 (42 U.S.C. 1395l(b)) is amended—

(A) in subsection (a)(1)—

(i) by striking "and" before "(H)", and

(ii) by adding at the end the following: "and (I) with respect to expenses incurred for covered outpatient drugs, the amounts paid shall be the amounts determined under subsection (m)(2),";

(B) in subsection (b)—

(i) in clause (1), by inserting "or for covered outpatient drugs" after "1861(s)(10)(A)", and

(ii) in clause (2), by inserting "or with respect to covered outpatient drugs" after "home health services"; and

(C) by adding at the end the following new subsection:

"(m)(1)(A) Before applying paragraph (2) with respect to expenses incurred by an individual for covered outpatient drugs dispensed in a calendar year, the individual must establish that the individual has incurred expenses for such drugs dispensed in the year (during a period in which the individual is a entitled to benefits under this part) of the amount specified in subparagraph (C) for that year.

"(B) If an individual applies to the Secretary to establish that the individual has met the requirement of subparagraph (A), the Secretary shall promptly notify the individual (and, if the application was submitted by or through a participating pharmacy, the pharmacy) as to whether or not the individual has met such requirement.

"(C) The amount specified in this subparagraph for 1989 is $500. For each subsequent year, subject to subparagraph (D), the amount specified in this subparagraph is the amount specified in this subparagraph for the previous year increased by percentage change in

the medical care component of the consumer price index for all urban consumers (U.S. city average, as published by the Bureau of Labor Statistics) during the 12-month period ending with August in that previous year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the next highest multiple of $1. In September of each year (beginning with 1989) the Secretary shall publish the deductible established under this subparagraph for the following year.

"(D) If the monthly actuarial rate determined under section 1839(g)(1) for a year (after 1990) exceeds 120 percent of the monthly premium increase provided under section 1839(g)(2) for months in the preceding year, the Secretary shall increase the amount otherwise specified under subparagraph (C) for that year (and only for that year) by such an amount as will assure that—

"(i) the aggregate amount of the monthly premium increase provided under section 1839(g) for the year for all enrollees,

is equal to—

"(ii) the total of the benefits and administrative costs which the Secretary estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for covered outpatient drugs dispensed and related administrative costs incurred in such year for all such enrollees.

"(2) Subject to the deductible established under paragraph (1)(A), the amount payable under this part with respect to a covered outpatient drug is equal to the actual charge for the drug, or, if lower, the applicable payment limit described in paragraph (3).

"(3)(A) In the case of a covered outpatient drug that either is not a multiple source drug (as defined in paragraph (6)(A)) or is a multiple source drug and has a restrictive prescription (as defined in paragraph (6)(B)), the payment limit for the drug under this paragraph is the sum of—

"(i) the product of (I) the number of tablets (or other dosage units) dispensed and (II) the average per tablet or unit wholesale price for the drug (as determined under paragraph (4)), and

"(ii) an administrative allowance of $4.50.

"(B) In the case of a covered outpatient drug that is a multiple source drug but does not have a restrictive prescription, the payment limit for the drug under this paragraph is the sum of—

"(i) the product of (I) the number of tablets (or other dosage units) dispensed and (II) the amount specified under subparagraph (C), and

"(ii) an administrative allowance of $4.50.

"(C) The amount specified under this subparagraph with respect to a multiple source drug dispensed in a year is 50 percent of the highest of the average per tablet or unit wholesale price for any drug product described in paragraph (5)(A) with respect to that drug, as in effect as of January 1, 1987, increased, for each year after 1987 and up to the year involved, by the percentage increase in the consumer price index for all urban consumers (all items, U.S. city average, as published by the Bureau of Labor Statistics) for the 12-month period ending in August of the previous year.

"(D) The Secretary, before each payment calculation period (as defined in paragraph (5)(C)), shall provide for the distribution to

participating pharmacies (as defined in section 1842(i)) and to groups representing or assisting individuals entitled to benefits under this part, of information on the payment limits established under this paragraph.

"(4)(A) For purposes of this subsection, the Secretary shall determine, with respect to dispensing of each covered outpatient drug in each payment calculation period, the average per tablet or unit wholesale price for the drug. Such average shall be based on the average wholesale price (or when available, the manufacturer's direct price) for purchases in reasonable quantities. Such determination shall be made for each payment calculation period based on wholesale or direct prices for the first day of the third month before the beginning of the period. The Secretary shall make such determination, and calculate the payment limits under paragraph (3), on a national basis; except that the Secretary may make such determination, and calculate such payment limits, on a regional basis to take account of limitations on the availability of drug products and variations among regions in the average wholesale or direct price for a drug product.

"(B) In order to prevent abusive practices in the prescribing or dispensing of covered outpatient drugs, the Secretary may provide that payment for covered outpatient drugs may not be made in they are prescribed or dispensed with excessive frequency or in excessive quantities.

"(5) In this subsection:

"(A) The term 'multiple source drug' means, with respect to a payment calculation period, a covered outpatient drug for which there are 2 or more drug products which—

"(i) are considered to be therapeutically equivalent (under the Food and Drug Administration's most recent publication of 'Approved Drug Products with Therapeutic Equivalence Evaluations', available on the first day of the third month before the beginning of the period), and

"(ii) are sold or marketed during the period.

For purposes of clause (ii), a drug is considered to be sold or marketed during a period if it is listed in the publications referred to in clause (i) for the third month before the beginning of the period, unless the Secretary determines that such sale or marketing is not actually taking place.

"(B) A drug has a 'restrictive prescription' only if the the prescription for the drug indicates, in the handwriting of the physician or other person prescribing the drug and with an appropriate phrase (such as 'brand medically necessary') recognized by the Secretary, that the particular drug must be dispensed.

"(C) The term 'payment calculation period' means the 6-month period beginning with January of each year (after 1988) and the 6-month period beginning with July of each year (after 1988).".

(2) REPORT ON PAYMENT LIMITS.—The Secretary of Health and Human Services shall review the payment limits described in section 1833(m)(3) of the Social Security Act on covered outpatient drugs and shall report to Congress, by not later than April 1, 1989, on the appropriateness of such limits. The Secre-

tary shall include in such report such recommendations for changes in such limits as may be appropriate.

(c) PARTICIPATING PHARMACIES.—Section 1842 (42 U.S.C. 1395t) is amended—

(1) in subclauses (III) and (IV) of subsection (c)(2)(B)(ii), by inserting "or by participating pharmacies" after "participating physicians" each place it appears;

(2) in subsection (h)(1), by inserting before the period at the end of the second sentence the following: "and, with respect to a supplier of covered outpatient drugs, is a participating pharmacy (as defined in subsection (i)(1))"; and

(3) by adding after subsection (h) the following new subsection:

"(i)(1) For purposes of this section, the term 'participating pharmacy' means an entity which is authorized under a State law to dispense covered outpatient drugs and which has entered into an agreement with the Secretary, providing at least the following:

"(A) The entity agrees—

"(i) not to refuse to dispense covered outpatient drugs items stocked by the entity to any individual entitled to benefits under this part (in this section referred to as 'medicare beneficiaries'), and

"(ii) not to charge medicare beneficiaries more for such drugs than the amount it charges to the general public.

"(B) The entity agrees to keep patient records (including records on expenses incurred by medicare beneficiaries) for all covered outpatient drugs dispensed to all such beneficiaries.

"(C) The entity agrees—

"(i) to assist medicare beneficiaries in determining whether or not their expenses (for covered outpatient drugs dispensed in a year) have exceeded the deductible under section 1833(m)(1)(A), including providing the documentation necessary to establish this, and

"(ii) on behalf and on the request of such a beneficiary, to submit to the carrier such documentation as the Secretary requires.

"(D) The entity agrees, upon request of a medicare beneficiary, to provide a copy of the records maintained under subparagraph (B) to another participating pharmacy or to a carrier under this section.

"(E) The entity agrees—

"(i) to offer to counsel, or to offer to provide information to, each medicare beneficiary on the appropriate use of a drug to be dispensed and whether there are potential interactions between the drug and other drugs dispensed to the beneficiary; and

"(ii) to advise the beneficiary on the availability (consistent with State laws respecting substitution of drugs) of therapeutically equivalent covered outpatient drugs.

"(2) The Secretary shall provide to each participating pharmacy—

"(A) a distinctive emblem (suitable for display to the public) indicating that the pharmacy is a participating pharmacy, and

"(B) before the beginning of each payment calculation period, information on the payment limits established under paragraphs (3) and (4) of section 1833(m).

"(3) The Secretary shall provide for periodic audits of participating pharmacies to assure that they do not impose charges in excess of the amounts permitted under paragraph (1)(A)(ii).

"(4) Notwithstanding subsection (b)(3)(B), payment for covered outpatient drugs may be made on the basis of an assignment described in clause (ii) of that subsection only to a participating pharmacy.".

(d) ADDITIONAL PREMIUM FOR PRESCRIPTION DRUG BENEFIT.—Section 1839 (42 U.S.C. 1395r) is amended—

(1) in the second sentence of subsection (a)(1), by inserting "(other than costs relating to covered outpatient drugs)" before the period;

(2) in subsection (a)(2), by striking "and (e)" and inserting ", (e), and (g)";

(3) in subsection (a)(3), by striking "subsection (e)" and inserting "subsections (e) and (g)";

(4) in the second sentence of subsection (a)(4), by inserting "(other than costs relating to covered outpatient drugs)" before the period; and

(5) by adding at the end the following new subsection:

"(g)(1)(A) The Secretary shall, during September of 1987 and of each year thereafter, determine a monthly actuarial rate for covered outpatient drugs which shall be applicable for the succeeding calendar year.

"(B) Subject to subparagraph (C), such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to enrollees will equal 100 percent of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for covered outpatient drugs dispensed and related administrative costs incurred in such calendar year with respect to such enrollees.

"(C) In establishing the monthly actuarial rate under this paragraph for each year (after 1990), the Secretary shall take into account any net surplus or deficit of the aggregate amount of the monthly premium increases provided under paragraph (2) for previous years for all enrollees over the total of the benefits and administrative costs which the Secretary determines were paid from the Federal Supplementary Medical Insurance Trust Fund for covered outpatient drugs dispensed and related administrative costs incurred in such previous years for all such enrollees.

"(2) Subject to paragraph (3), notwithstanding any other provision of this section (except as provided in subsections (b) and (f)), the monthly premium of each individual enrolled under this part for each month in a year after December 1987 shall be increased by the monthly actuarial rate determined according to paragraph (1) for that year; except that if the increase determined under this paragraph is not a multiple of 10 cents, it shall be rounded to the nearest multiple of 10 cents.

"(3) The increase in monthly premium under paragraph (2) for each month in—

"(A) 1988 may not exceed $0.30,
"(B) 1989 may not exceed $3.20,
"(C) 1990 may not exceed $4.90, and
"(D) a subsequent year may not exceed 120 percent of the monthly premium increase provided under paragraph (2) for months in the preceding year.".

(e) USE OF CARRIERS IN ADMINISTRATION.—

(1) ADDITIONAL FUNCTIONS OF CARRIERS.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)), as amended by section 201(c), is amended—

(A) by striking "and" at the end of subparagraph (H),
(B) by adding "and" at the end of subparagraph (I), and
(C) by inserting after subparagraph (I) the following new subparagraph:

"(J) if it makes determinations or payments with respect to covered outpatient drugs, will—

"(i) offer, at the option of participating pharmacies, to receive requests for payments for such drugs through electronic communciations, and

"(ii) respond to requests by participating pharmacies as to whether or not an individual has met the deductible requirement of section 1833(m)(1)(A) for a year;".

(2) USE OF REGIONAL CARRIERS.—Section 1842(b)(2) is amended by adding at the end the following new sentence: "With respect to carrying out functions relating to payment for the Secretary may enter into contracts with carriers under this section to perform such functions on a regional basis.".

(f) MODIFICATION OF HMO/CMP RISK-SHARING CONTRACTS.—

(1) COUNTING OF EXPENSES BEFORE ENROLLMENT.—Section 1876(c) (42 U.S.C. 1395mm(c)) is amended by adding at the end the following new paragraph:

"(8) In the case of an individual who enrolls as a member of an eligible organization under this section after January 1 of a year, the organization must take into account, in computing the expenses incurred for covered outpatient drugs for purposes of meeting the deductible under section 1833(m)(1)(A) for the year, expenses incurred for covered outpatient drugs during the year while the individual was entitled to benefits under part B but before the individual so enrolled.".

(2) ADJUSTMENT OF AAPCC AND CONTRACTS.—The Secretary of Health and Human Services shall—

(A) in estimating the adjusted average per capita cost under section 1876(a) of the Social Security Act for, portions of contract years occurring after December 31, 1988, take into account the amendments made by this section, and

(B) require eligible organizations with risk-sharing contracts under such section to make appropriate adjustments in the terms of their agreements with medicare beneficiaries to take into account such amendments.

(g) CONFORMING AMENDMENTS.—

(1) Section 1844(a) (42 U.S.C. 1395w(a)(1)) is amended by adding at the end the following:

"In computing the amount of aggregate premiums and premiums per enrollee under paragraph (1), there shall not be taken into account premiums attributable to section 1839(g).".

(2) The first sentence of section 1866(a)(2)(A)(i) (42 U.S.C. 1395cc(a)(2)(A)(i)) is amended by inserting "the amount of any deduction imposed pursuant to section 1833(m)(1) with respect to covered outpatient drugs" after "items and services by such provider)".

(3) Section 1905(p) (42 U.S.C. 1396d(p)) is amended—

(A) in paragraph (3)(C) (as subsequently amended by section 208(d)(2) of this Act), by inserting "and, subject to paragraph (4), the annual deductible under section 1833(m)(1)" after "1833(b)"; and

(B) by adding at the end the following new paragraph:

"(4) Instead of providing to qualified medicare beneficiaries, under paragraph (3)(C), medicare cost-sharing with respect to the annual deductible for covered outpatient drugs under section 1833(m)(1), a State may provide to such beneficiaries, before charges for covered outpatient drugs for a year reach such deductible amount, benefits for prescribed drugs in the same amount, duration, and scope as the benefits made available under the State plan for individuals described in subsection (a)(10)(A)(i).".

(h) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to covered outpatient drugs dispensed on or after January 1, 1989.

(2) PREMIUMS—The amendments made by subsection (d) and (g)(1) shall apply to premiums for months beginning with January 1988.

(3) CARRIERS.—The amendments made by this subsection (e) shall take effect on the date of the enactment of this Act.

(4) HMO/CMP ENROLLMENTS.—The amendment made by subsection (f)(1) shall apply to enrollments effected on or after January 1, 1989.

(5) MEDICAID CHANGES.—(A) The amendments made by subsection (g)(3) apply (except as provided in subparagraph (B)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1988, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, with respect to medical assistance for—

(i) monthly premiums under title XVIII of such Act for months beginning with July 1988, and

(ii) covered outpatient drugs dispensed on or after January 1, 1989.

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by subsection (g)(3), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first session of the

State legislature that begins after the date of the enactment of this Act.

SEC. 203. IN-HOME CARE FOR CERTAIN CHRONICALLY DEPENDENT INDIVIDUALS.

(a) IN GENERAL.—Section 1832(a) (42 U.S.C. 1395k(a)) is amended—

(1) by amending subparagraph (A) of paragraph (2) to read as follows:

"(A)(i) home health services, and (ii) subject to section 1839(h)(4), in-home care for a chronically dependent individual for up to 120 hours in any calendar year;"; and

(2) by adding at the end the following new sentence:

"In the case of in-home care (described in paragraph (2)(A)(ii)) provided to a chronically dependent individual on any day, such care provided for 3 hours or less on the day shall be counted (for purposes of the limitation in such paragraph) as 3 hours of such care.".

(b) IN-HOME CARE FOR CHRONICALLY DEPENDENT INDIVIDUAL DEFINED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"In-Home Care; Chronically Dependent Individual

"(ff)(1) The term 'in-home care' means the following items and services furnished, under the supervision of a registered professional nurse, to a chronically dependent individual (as defined in paragraph (2)) by a home health agency or by others under arrangements with them made by such agency in a place of residence used as such individual's home:

"(A) Services of a homemaker/home health aide (who has successfully completed a training program approved by the Secretary).

"(B) Personal care services.

"(C) Nursing care provided by a licensed professional nurse.

"(2) The term 'chronically dependent individual' means an individual who—

"(A) is dependent on a daily basis on a primary caregiver who is living with the individual and is assisting the individual without monetary compensation in the performance of at least 2 of the activities of daily living (described in paragraph (3)), and

"(B) without such assistance could not perform such activities of daily living.

"(3) The 'activities of daily living', referred to in paragraph (2), are as follows:

"(i) Eating.

"(ii) Bathing.

"(iii) Dressing.

"(iv) Toileting.

"(v) Transferring in and out of a bed or in and out of a chair.".

(c) PAYMENT.—Section 1833(a) (42 U.S.C. 1395l(a)) is amended—

(1) in paragraph (2), by inserting "(A)(ii)," after "subparagraphs" the first place it appears,

(2) in paragraph (3), by striking "(D)" and inserting "(A)(ii), (D),", and

(3) by adding at the end the following:

"Payment for in-home care for chronically dependent individuals shall be paid on the basis of an hour of such care provided.".

(d) CERTIFICATION.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)) is amended—

(1) by striking "and" at the end of subparagraph (D);

(2) by striking the period at the end of subparagraph (E) and inserting in lieu thereof "; and"; and

(3) by inserting after subparagraph (E) the following new subparagraph:

"(F) in the case of in-home care provided to a chronically dependent individual during a 12-month period, the individual was a chronically dependent individual during the 3-month period immediately preceding the beginning of the 12-month period.".

(e) ADDITIONAL PREMIUM FOR IN-HOME CARE.—Section 1839 (42 U.S.C. 1395r), as amended by section 202(d), is amended—

(1) in the second sentence of subsection (a)(1), by inserting "and costs relating to in-home care, as defined in section 1861(ff)(1)" after "covered outpatient drugs";

(2) in subsection (a)(2), by striking "and (g)" and inserting "(g), and (h)";

(3) in subsection (a)(3), by striking "and (g)" and inserting ", (g), and (h)";

(4) in the second sentence of subsection (a)(4), by inserting "and costs relating to in-home care, as defined in section 1861(ff)(1)" after "covered outpatient drugs"; and

(5) by adding at the end the following new subsection:

"(h)(1)(A) The Secretary shall, during September of 1988 and of each year thereafter, determine a monthly actuarial rate for in-home care (as defined in section 1861(ff)(1)) which shall be applicable for the succeeding calendar year.

"(B) Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to enrollees will equal 100 percent of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for in-home care provided and related administrative costs incurred in such calendar year with respect to such enrollees.

"(C) In establishing the monthly actuarial rate under this paragraph for each year (after 1990), the Secretary shall take into account any net surplus or deficit of the aggregate amount of the monthly premium increases provided under paragraph (2) for previous years for all enrollees over the total of the benefits and administrative costs which the Secretary determines were paid from the Federal Supplementary Medical Insurance Trust Fund for in-home care provided and related administrative costs incurred in such previous years for all such enrollees.

"(2) Subject to paragraph (3), notwithstanding any other provision of this section (except as provided in subsections (b) and (f)), the monthly premium of each individual enrolled under this part for each month in a year after December 1988 shall be increased by

the monthly actuarial rate determined according to paragraph (1) for that year; except that if the increase determined under this paragraph is not a multiple of 10 cents, it shall be rounded to the nearest multiple of 10 cents.

"(3) The increase in monthly premium under paragraph (2) for each month in—

"(A) 1989 may not exceed $0.40,

"(B) 1990 may not exceed $0.70, and

"(C) a subsequent year may not exceed 120 percent of the monthly premium increase provided under paragraph (2) for months in the preceding year.

"(4) If the monthly actuarial rate determined under paragraph (1) for a year (after 1990) exceeds 120 percent of the monthly premium increase provided under paragraph (2) for months in the preceding year, the Secretary shall decrease the maximum number of hours of in-home care under section 1832(a)(2)(A)(ii) in that year (and only in that year) by such an amount as will assure that—

"(A) the aggregate amount of the monthly premium increase provided under this subsection for the year for all enrollees,

is equal to—

"(B) the total of the benefits and administrative costs which the Secretary estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for in-home care provided and related administrative costs incurred in such year for all such enrollees.".

(f) STANDARDS FOR UTILIZATION.—

(1) Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (A), by striking "subparagraphs (B), (C), or (D)" and inserting "a succeeding subparagraph of this paragraph",

(ii) by striking "and" at the end of subparagraph (D),

(iii) by adding "and" at the end of subparagraph (E), and

(iv) by adding at the end the following new subparagraph:

"(F) in the case of in-home care for chronically dependent individuals, which is not reasonable and necessary to assure the health and condition of the individual is maintained in the individual's noninstitutional residence;"; and

(B) in paragraph (6), by inserting "and except, in the case of in-home care, as is otherwise permitted under paragraph (1)(F)" after "paragraph (1)(C)".

(2) The Secretary of Health and Human Services shall take appropriate efforts to assure the quality, and provide for appropriate utilization of, in-home care for chronically dependent individuals under the amendments made by this section.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1989; except that the amendments made by subsection (e) shall apply to premiums for months beginning with January 1989.

(h) STUDY OF ALTERNATIVE OUT-OF-HOME SERVICES.—The Secretary of Health and Human Services shall study, and report to Con-

gress, not later than 18 months after the date of the enactment of this Act, on the advisability of providing, to chronically dependent individuals eligible for in-home care under the amendments made by this section, out-of-home services (such as adult day care services or nursing facility services) as alternative services to in-home care.

(i) STUDY OF IN-HOME CARE.—The Secretary shall study, and report to Congress, not later than January 1, 1991, on the extent of use, cost, and effectiveness of in-home care provided to chronically dependent individuals under the amendments made by this section.

SEC. 204. EXTENDING HOME HEALTH SERVICES.

(a) COVERAGE.—Section 1861(m) (42 U.S.C. 1395x(m)) is amended by adding at the end the following new sentence: "For purposes of paragraphs (1) and (4) and sections 1814(a)(2)(C) and 1835(a)(2)(A), nursing care and home health aide services shall be considered to be provided or needed on an 'intermittent' basis if they are provided or needed less than 7 days each week and, in the case they are provided or needed for 7 days each week, if they are provided or needed for an initial period of up to 35 consecutive days, and for a subsequent period based on a physician certification of exceptional circumstances requiring such services on such a basis.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after January 1, 1989.

SEC. 205. INCREASE IN MAXIMUM PAYMENT ALLOWED FOR OUTPATIENT MENTAL HEALTH SERVICES.

(a) IN GENERAL.—Section 1833(c) (42 U.S.C. 1395l(c)) is amended—

(1) in paragraph (1), by striking "$312.50" and inserting "the amount specified in paragraph (2) for that year";

(2) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B);

(3) by inserting "(1)" after "(c)"; and

(4) by adding at the end the following new paragraph:

"(2) The amount specified in this paragraph for 1989 is $1,250. The amount specified in this paragraph for each succeeding year is the amount specified in this paragraph for the preceding year increased by the percentage increase in the MEI (as defined in section 1842(b)(4)(E)(ii)) for the year involved. If any amount determined under the previous sentence is not a multiple of $10, it shall be rounded to the nearest multiple of $10.".

(b) CONFORMING AMENDMENTS.—(1) Section 1833(f), as inserted by section 201 of this Act, is amended by adding at the end the following new paragraph:

"(5) In applying paragraphs (1) and (2), the amount specified in subsection (c)(2) is deemed to be $312.50.".

(2) Section 1833(c) (42 U.S.C. 1395l(c)), as amended by subsection (a), is further amended by adding at the end the following new paragraph:

"(3) In this subsection, the term 'treatment' shall not be construed as including medical management visits.".

(3) The second sentence of section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended by striking "1833(c)" and inserting "1833(c)(1)".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to expenses incurred for services furnished on or after January 1, 1989.

SEC. 206. COVERAGE OF INFLUENZA VACCINE AND ITS ADMINISTRATION.

(a) IN GENERAL.—Section 1861(s)(10)(A) (42 U.S.C. 1395x(a)(10)(A)) is amended by inserting before the semicolon the following: "and influenza vaccine and its administration".

(b) ADDITIONAL PREMIUM FOR INFLUENZA VACCINE.—Section 1839 (42 U.S.C. 1395r), as amended by sections 202(d) and 203(e), is amended—

(1) in the second sentence of subsection (a)(1)—

(A) by striking "and costs" and inserting ", costs", and

(B) by inserting "and costs relating to influenza vaccine and its administration" after "section 1861(ff)(1)";

(2) in subsection (a)(2), by striking "and (h)" and inserting "(h), and (i)";

(3) in subsection (a)(3), by striking "and (h)" and inserting "(h), and (i)";

(4) in the second sentence of subsection (a)(4)—

(A) by striking "and costs" and inserting ", costs", and

(B) by inserting "and costs relating to influenza vaccine and its administration" after "section 1861(ff)(1)"; and

(5) by adding at the end the following new subsection:

"(i)(1) The Secretary shall, during September of 1988 and of each year thereafter, determine a monthly actuarial rate for influenza vaccine and its administration which shall be applicable for the succeeding calendar year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to enrollees will equal 100 percent of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for influenza vaccine and related administrative costs incurred in such calendar year with respect to such enrollees.

"(2) Notwithstanding any other provision of this section (except as provided in subsections (b) and (f)), the monthly premium of each individual enrolled under this part for each month in a year after December 1988 shall be increased by the monthly actuarial rate determined according to paragraph (1) for that year; except that if the increase determined under this paragraph is not a multiple of 10 cents, it shall be rounded to the nearest multiple of 10 cents.".

(c) EFFECTIVE DATES.—The amendment made by subsection (a) shall apply to influenza vaccine administered on or after January 1, 1989, and the amendments made by subsection (b) shall apply to premiums for months beginning with January 1989.

SEC. 207. MAILING OF NOTICE OF MEDICARE BENEFITS AND PARTICIPATING PHYSICIAN DIRECTORIES.

(a) DISTRIBUTION OF NOTICE OF MEDICARE BENEFITS.—Title XVIII is amended by inserting after section 1803 the following new section:

"NOTICE OF MEDICARE BENEFITS

"SEC. 1804. (a) The Secretary shall distribute annually a notice containing—

"(1) a clear, simple explanation of the benefits available under this title and health care services for which benefits are not available under this title, and

"(2) a description of the limited benefits for long-term care services available under this title and generally available under State plans approved under title XIX.

Such notice shall be mailed annually to individuals entitled to benefits under part A or part B of this title.

"(b) There are authorized to be appropriated in equal proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund such sums as may be required to provide for the annual publication and distribution of the notice described in subsection (a).".

(b) DISTRIBUTION OF PARTICIPATING PHYSICIAN DIRECTORIES.—The second sentence of section 1842(h)(6) (42 U.S.C. 1395u(h)(6)) is amended by inserting after "that area" the following: "and to each individual enrolled under this part and residing in that area".

(c) EFFECTIVE DATES.—

(1) The Secretary of Health and Human Services shall first distribute the notice required by the amendment made by subsection (a) not later than January 31, 1988, or, if later, 3 months after the date of the enactment of this Act.

(2) The amendment made by subsection (b) shall first apply to directories for 1988.

SEC. 208. REQUIRING MEDICAID BUY-IN OF PREMIUMS AND COST-SHARING FOR POOR MEDICARE BENEFICIARIES.

(a) REQUIREMENT.—(1) Section 1902(a)(10)(E) (42 U.S.C. 1396a(a)(10)(E)) is amended by striking "at the option of a State, but".

(2) Section 1905(p)(1)(B) (42 U.S.C. 1396d(p)(1)(B)) is amended by striking "and the election of the State".

(b) SETTING INCOME STANDARD AT 100 PERCENT OF POVERTY LEVEL.—Section 1905(p)(2)(A) (42 U.S.C. 1396d(p)(2)(A)) is amended by striking "may not exceed a percentage (not more than 100 percent) of the nonfarm" and inserting "shall be 100 percent of the".

(c) RESOURCE STANDARD.—Section 1905(p) (42 U.S.C. 1396d(p)) is amended—

(1) in paragraph (1)(C), by striking "(2)(A)" and inserting "(2)";

(2) in paragraph (1)(D), by striking "(except as provided in paragraph (2)(B))" and inserting "twice"; and

(3) in paragraph (2)—

(A) in subparagraph (A), by striking "(2)(A)" and inserting "(2)", and

(B) by striking subparagraph (B).

(d) MEDICARE COVERAGE.—Section 1905(p)(3) (42 U.S.C. 1396d(p)(3)) is amended—

(1) in subparagraph (A), by striking "under part B and (if applicable) under section 1818" and inserting "under title XVIII

(including under part B and, if applicable, under section 1818)"; and

(2) by amending subparagraphs (B) and (C) to read as follows:

"(B) Coinsurance under title XVIII (including coinsurance described in section 1813).

"(C) Deductibles established under title XVIII (including those described in section 1813 and 1833(b))."

(e) CONFORMING AMENDMENTS.—(1) Section 1902(a)(10)(A)(i) (42 U.S.C. 1396a(a)(10)(A)(i)) is amended by adding after and below subclause (III) the following:

"and, to the extent required under subsection (m)(3), some or all of the individuals described in subsection (l)(1);".

(2) Section 1843 (42 U.S.C. 1395v) is amended by inserting "or after 1987" in subsections (a), (g)(1), and (h)(1) after "during 1981".

(f) TECHNICAL AMENDMENT.—Effective as though included in the enactment of the Omnibus Budget Reconciliation Act of 1986, paragraph (2) of section 9403(g) of such Act is amended to read as follows:

"(2) PAYMENT OF MEDICARE COST-SHARING.—Section 1903(a)(1) of such Act (42 U.S.C. 1396b(a)(1)) is amended by inserting 'including expenditures for medicare cost-sharing and' before 'including expenditures.'."

(g) TREATMENT OF CERTAIN STATES.—

(1) STATES OPERATING UNDER DEMONSTRATION PROJECTS.—In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115 of the Social Security Act, the Secretary of Health and Human Services shall require the State to meet the requirement of section 1902(a)(10)(E) of the Social Security Act in same manner as the State would be required to meet such requirement if the State had in effect a plan approved under title XIX of such Act.

(2) COMMONWEALTHS AND TERRITORIES.—Section 1905(p) (42 U.S.C. 1396d(p)), as amended by section 202(g)(3)(B), is amended by adding at the end the following new paragraph:

"(5) Notwithstanding any other provision of this title, in the case of a State (other than the 50 States and the District of Columbia)—

"(A) the requirement stated in section 1902(a)(10)(E) shall be optional, and

"(B) for purposes of paragraph (2)(A), the State may substitute for 100 percent any lesser percentage.".

(h) EFFECTIVE DATE.—(1) The amendments made by this section apply (except as provided in subsection (f) and under paragraph (2)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1988, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, with respect to medical assistance for—

(A) monthly premiums under title XVIII of such Act for months beginning with July 1988, and

(B) items and services furnished on and after July 1, 1988.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than

legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first session of the State legislature that begins after the date of the enactment of this Act.

SEC. 209. ADJUSTMENT IN MEDICARE PART B PREMIUM.

(a) TRANSITIONAL ADJUSTMENTS IN 1990 AND 1991.—Section 1839(e) (42 U.S.C. 1395r(e)) is amended by adding at the end the following new paragraph:

"(3)(A) Notwithstanding the provisions of subsection (a), but subject to the provisions of subsections (g), (h), and (i) the monthly premium for each individual enrolled under this part for each month—

"(i) in 1990 shall be $1.00 greater than the amount otherwise determined under subsection (a), and

"(ii) in 1991 shall be 40 cents greater than the amount otherwise determined under subsection (a).

Any increases in premium amounts taking effect under this paragraph for months in a year shall be taken into account for purposes of determining increases in each subsequent year under subsection (a)(3).

"(B) Subparagraph (A) does not apply to premiums determined under paragraph (4) or (5).".

(b) PART B PREMIUM FOR RESIDENTS OF U.S. COMMONWEALTHS AND TERRITORIES.—Such section is further amended by adding at the end the following new paragraph:

"(4)(A) Notwithstanding the provisions of subsection (a), but subject to subsections (g), (h), and (i), in the case of an individual who is a resident of a commonwealth or territory during a month—

"(i) in 1988 or 1989, the monthly premium otherwise determined for the individual under paragraph (1) or subsection (a)(3), respectively, shall be increased by the amount described in subparagraph (B) for that month; or

"(ii) in a subsequent year, the monthly premium which shall apply shall be the amount described in subparagraph (C) for that month.

"(B) The amount described in this subparagraph for a month in 1988 or 1989 for an individual residing in a particular commonwealth or territory is 1/12th of the product of—

"(i) the average, per capita additional benefits (and related administrative costs), as determined by the Secretary during September of the previous year, that will be payable under this title during the year by reason of the amendments made by the Medicare Catastrophic Protection Act of 1987 (other than sections 202, 203, and 206 thereof); and

"(ii) the ratio (determined by the Secretary for that commonwealth or territory during September 1987) of—

"(I) the per capita actuarial value of the benefits under this title for residents of the commonwealth or territory who are entitled to benefits under both part A and this part, to

"(II) the per capita actuarial value of the benefits under this title for residents of the United States who are entitled to benefits under both part A and this part.

"(C) The amount described in this subparagraph for a month in—

"(i) 1990, is the sum of—

"(I) the monthly premium established under subsection (a)(3) for months in 1989, and

"(II) the amount described in subparagraph (B) for months in 1989,

increased by the premium percentage increase (as defined in subparagraph (E)(ii)) for 1990; or

"(ii) a succeeding year is the amount described in this subparagraph for months in the previous year increased by the premium increase percentage for that succeeding year.

"(D) If any amount determined under the previous provisions of this subparagraph is not a multiple of 10 cents, the Secretary shall round the amount to the nearest multiple of 10 cents.

"(E) In this paragraph:

"(i) The term 'commonwealth or territory' means Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands.

"(ii) The term 'percentage premium increase', for a year, means the percentage determined under subsection (a)(3)(B) in the previous year.".

(c) PART B PREMIUM FOR INDIVIDUALS ENROLLED UNDER PART B BUT NOT ENTITLED TO BENEFITS UNDER PART A.—Such section is further amended by adding at the end the following new paragraph:

"(5)(A) Notwithstanding the provisions of subsection (a), but subject to subsections (g), (h), and (i), in the case of a part B only individual (as defined in subparagraph (E)) during a month—

"(i) in 1989, the monthly premium otherwise determined for the individual under subsection (a)(3) shall be increased by the amount described in subparagraph (B); or

"(ii) in a subsequent year, the monthly premium which shall apply shall be the amount described in subparagraph (C) for that month.

"(B) The amount described in this subparagraph is 1/12th of the average, per capita additional benefits (and related administrative costs) that the Secretary estimates (during September of 1988) will be payable under this part during 1989 by reason of the amendments made by the Medicare Catastrophic Protection Act of 1987 (other than sections 202, 203, and 206 thereof).

"(C) The amount described in this subparagraph for a month—

"(i) in 1990, is the sum of—

"(I) the monthly premium established under subsection (a)(3) for months in 1989, and

"(II) the amount described in subparagraph (B),

increased by the premium percentage increase (as defined in paragraph (4)(E)(ii)) for 1990; or

"(ii) in a succeeding year is the amount described in this subparagraph for months in the previous year increased by the premium increase percentage (as so defined) for that succeeding year.

"(D) If any amount determined under the previous provisions of this paragraph is not a multiple of 10 cents, the Secretary shall round the amount to the nearest multiple of 10 cents.

"(E) In this paragraph the term 'part B only individual' means, with respect to a premium for a month, an individual who—

"(i) is not a resident of a commonwealth or territory (as defined in paragraph (4)(E)(i)) during the month,

"(ii) is entitled to benefits under this part, and

"(iii) is not entitled to (or, on application without payment of an additional premium, would not be entitled to) benefits under part A.".

(d) CONFORMING AMENDMENTS.—

(1) Section 1839(b) (42 U.S.C. 1395r(b)) is amended by striking "determined under subsection (a) or (e)" and inserting "otherwise determined under this section (without regard to subsection (f))".

(2) Section 1839 (42 U.S.C. 1395r), as amended by sections 202(d), 203(e), and 206(b), is amended—

(A) in the second sentence of subsection (a)(1)—

(i) by striking "and costs" and inserting ", costs", and

(ii) by inserting ", and costs attributable to section 1812(f)" after "influenza vaccine and its administration"; and

(B) in the second sentence of subsection (a)(4)—

(i) by striking "and costs" and inserting ", costs", and

(ii) by inserting ", and costs attributable to section 1812(f)" after "influenza vaccine and its administration".

(3) The last sentence of section 1844(a) (42 U.S.C. 1395w(a)(1)), as added by section 202(g)(1), is amended by inserting before the period at the end the following: "such premiums shall be computed as though the clause '(other than costs attributable to section 1812(f))' was deleted from paragraphs (1) and (4) of section 1839(a)".

(e) EFFECTIVE DATES.—

(1) The amendments made by subsection (a) shall apply to monthly premiums for months beginning with January 1990.

(2) The amendments made by subsection (b) shall apply to monthly premiums for months beginning with January 1988.

(3) The amendment made by subsections (c) and (d) shall apply to monthly premiums for months beginning with January 1989.

SEC. 210. CHANGES IN CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES.

(a) ESTABLISHMENT OF NEW MEDIGAP STANDARDS.—

(1) RECOMMENDED CHANGES.—The Secretary of Health and Human Services shall report to Congress, not later than 150 days after the date of the enactment of this Act, on changes that should be made in the requirements of subsection (c) of section 1882 of the Social Security Act for certification of medicare supplemental policies to take into account both the

amendments made by this Act, and by any other pertinent Acts enacted by the first session of the 100th Congress, and any recommendations developed by the National Association of Insurance Commissioners.

(2) CONGRESSIONAL ACTION.—It is the sense of Congress that—

(A) Congress will promptly act on such recommendations and provide for appropriate changes in the requirements of subsection (c) of that section, and

(B) States will be expected to adjust their laws in a timely manner to comply with the changes in such requirements.

(b) REQUIRED MAILING OF NOTICE.—

(1) IN GENERAL.—Section 1882(b) (42 U.S.C. 1395ss(b)) is amended by adding at the end the following new paragraph:

"(3) Notwithstanding paragraph (1), in the case of a medicare supplemental policy offered in a State and in effect on January 1, 1988, the policy shall not be deemed to meet the standards and requirements set forth in subsection (c), unless each individual who is entitled to benefits under this title and is a policyholder under such policy on January 1, 1988, is sent a letter by not later than January 31, 1988, that explains—

"(A) the improved benefits under this title contained in legislation enacted by the first session of the 100th Congress, and

"(B) how these improvements affect the benefits contained in the policies and the premium for the policy.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to medicare supplemental policies as of February 1, 1988.

(c) REQUIRED SUBMISSION OF ADVERTISING.—

(1) IN GENERAL.—Section 1882(b) is further amended by adding after paragraph (3) the following new paragraph:

"(4) Notwithstanding paragraph (1), a medicare supplemental policy offered in a State shall not be deemed to meet the standards and requirements set forth in subsection (c), with respect to a advertisment (whether through written, radio, or television medium) used (or, at a State's option, to be used) for the policy in the State, unless the entity issuing the policy provides a copy of each advertisement to the Commissioner of Insurance (or comparable officer identified by the Secretary) of that State for his or her review in accordance with State law.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to medicare supplemental policies as of January 1, 1988, with respect to advertising used on or after such date.

(d) TRANSITION FOR CURRENT POLICIES.—Notwithstanding any other provision of law, during the period beginning on January 1, 1988, and ending on December 31, 1988, no penalty may be imposed under subparagraph (A) of section 1882(d)(3) of the Social Security Act with respect to a medicare supplemental policy which—

(1) is being offered as of (and has been offered before) the date of the enactment of this Act, and

(2) would not substantially duplicate health benefits to which an individual is otherwise entitled under title XVIII of such Act but for the amendments made by this Act.

SEC. 211. EXTENSION OF SOCIAL HMO DEMONSTRATION PROJECT.

(a) THROUGH SEPTEMBER 30, 1992.—The Secretary of Health and Human Services shall extend without interruption, through September 30, 1992, the approval of waivers granted under subsection (a) of section 2355 of the Deficit Reduction Act of 1984 for the demonstration project described in subsection (b) of that section, subject to the terms and conditions (other than duration of the project) established under that section (as amended by subsection (b)).

(b) EXTENSION OF RISK.—Section 2355(b)(5) of the Deficit Reduction Act of 1984 is amended by inserting "and in succeeding years" after "third year".

(c) INTERIM REPORT.—Section 2355(d)(2) of the Deficit Reduction Act of 1984 is amended by striking "final" and inserting "interim".

(d) FINAL REPORT.—The Secretary shall submit a final report to the Congress on the project referred to in subsection (a) not later than March 31, 1993.

SEC. 212. STUDY ON COMPREHENSIVE MEDICAL COVERAGE UNDER THE MEDICARE PROGRAM.

(a) IN GENERAL.—The Comptroller General shall conduct a study to assess the need for, and cost of, including each of the following services in the medicare program for medicare beneficiaries:

(1) ANNUAL PREVENTIVE CARE VISITS.—Diagnostic procedures performed during an annual physician examination, including (as medically appropriate by sex) a routine Papanicolaou test for diagnosis of uterine cancer, blood pressure test, blood test for cholesterol levels, colorectal exam, and a mammogram.

(2) ROUTINE EYE CARE.—An annual vision examination and the dispensing of prescription eyeglasses.

(3) DENTAL CARE.—Dental services, including an annual dental examination and cleaning, tooth extractions, simple restorations, services required for dentures, surgical preparation of endentulous ridges, periodontal therapy, and endodontics.

(4) HEARING CARE.—Biannual hearing threshold testing and hearing aids for those with a significant hearing loss.

(5) LONG-TERM CARE SERVICES.—Comprehensive long-term care services (including adult day care services, intermediate care facility services, home- and community-based services, outpatient drug therapy, and respite care) provided on a case-managed basis in the environment of least restriction, where approved and regularly recertified by a geriatric assessment team.

(6) PRESCRIPTION DRUGS AND BIOLOGICALS.—Prescription drugs and biologicals.

(b) COST DETERMINATION.—The Comptroller General shall make separate determinations of the costs of each of the services described in subsection (a) on the basis of fee-for-service reimbursement and on the basis of a comprehensive capitation payment arrangement. Such costs shall be determined for fiscal year 1988 and each of the succeeding 4 fiscal years.

(c) REPORT.—The Comptroller General shall report to the Congress on the results of the study under this section not later than 6 months after the date of the enactment of this Act.

SEC. 213. RESEARCH ON LONG-TERM CARE SERVICES FOR MEDICARE BENEFICIARIES.

(a) IN GENERAL.—The Secretary of Health and Human Services, from the funds appropriated under subsection (b), shall provide for research on issues relating to the delivery and financing of long-term care services for medicare beneficiaries. Such research shall include research into at least the following areas:

(1) The financial characteristics of medicare beneficiaries who receive or need long-term care services, including whether such beneficiaries are eligible for medicaid benefits for such services.

(2) How the financial and other characteristics of medicare beneficiaries affect their utilization of institutional and noninstitutional long-term care services.

(3) How relatives of medicare beneficiaries are affected financially and in other ways because the beneficiaries require or receive long-term care services.

(4) The quality of long-term care services (in community-based and custodial settings) and how the provision of long-term care services may reduce expenditures for acute health care services.

(5) The effectiveness of, and need for, State and Federal consumer protections which assure adequate access to and protect the rights of medicare beneficiaries who are provided long-term care services (other than in a nursing facility).

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, in equal parts from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, $5,000,000 for each of fiscal years 1988, 1989, 1990, 1991, and 1992, to carry out the research described in subsection (a).

(c) LONG-TERM CARE SERVICES DEFINED.—In this section, the term "long-term care services" includes nursing home care, home care, community-based services, and custodial care.

SEC. 214. PROTECTION OF INCOME AND RESOURCES OF COUPLE FOR MAINTENANCE OF COMMUNITY SPOUSE.

(a) IN GENERAL.—Title XIX is amended—

(1) by redesignating section 1921 as section 1922, and

(2) by inserting after section 1920 the following new section:

"TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES

"SEC. 1921. (a) SPECIAL TREATMENT FOR INSTITUTIONALIZED SPOUSES.—

"(1) SUPERSEDES OTHER PROVISIONS.—In determining the eligibility for medical assistance of an institutionalized spouse (as defined in subsection (g)(1)), the provisions of this section supersede any other provision of this title (including sections 1902(a)(17) and 1902(f)) which is inconsistent with them.

"(2) NO COMPARABLE TREATMENT REQUIRED.—Any different treatment provided under this section for institutionalized spouses shall not, by reason of paragraph (10) or (17) of section 1902(a), require such treatment for other individuals.

"(3) DOES NOT AFFECT CERTAIN DETERMINATIONS.—Except as this section specifically provides, this section does not apply to—

"(A) the determination of what constitutes income or resources, or

"(B) the methodology and standards for determining and evaluating income and resources.

"(4) ELECTION TO USE OTHER RULES.—An institutionalized spouse may elect not to have this section (other than subsection (c)) apply but to have the spouse's resources and income determined under the law, practice, or policy of the plan (whether approved or not) in effect on March 1, 1987, except to the extent inconsistent with subsection (c).

"(5) APPLICATION IN CERTAIN STATES AND TERRITORIES.—

"(A) APPLICATION IN STATES OPERATING UNDER DEMONSTRATION PROJECTS.—In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirements of this section in same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title XIX.

"(B) NO APPLICATION IN COMMONWEALTHS AND TERRITORIES.—This section shall only apply to a State that is one of the 50 States or the District of Columbia.

"(b) RULES FOR TREATMENT OF INCOME.—

"(1) SEPARATE TREATMENT OF INCOME.—During any month in which an institutionalized spouse is in the institution, no income of the community spouse shall be deemed available to the institutionalized spouse.

"(2) ATTRIBUTION OF INCOME.—In determining the income of an institutionalized spouse or community spouse, except as otherwise provided in this section and regardless of any State laws relating to community property or the division of marital property, the following rules apply:

"(A) NON-TRUST PROPERTY.—Subject to subparagraphs (C) and (D), in the case of income not from a trust, unless the instrument providing the income otherwise specifically provides—

"(i) if payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

"(ii) if payment of income is made in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

"(iii) if payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each of the individuals named in equal proportional shares.

"(B) TRUST PROPERTY.—In the case of a trust—

"(i) except as provided in clause (ii), income shall be attributed in accordance with the provisions of this title (including sections 1902(a)(17) and 1902(k)), and

"(ii) unless the trust otherwise specifically provides—

"(I) if payment of income is made solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

"(II) if payment of income is made to both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

"(III) if payment of income is made to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each of such individuals in equal proportional shares.

"(C) PROPERTY WITH NO INSTRUMENT.—In the case of income not from a trust in which there is no instrument establishing ownership, subject to subparagraph (D), one-half of the income shall be considered to be available to the institutionalized spouse and one-half to the community spouse.

"(D) REBUTTING OWNERSHIP.—The rules of subparagraphs (A) and (C) are superceded to the extent that an institutionalized spouse can establish, by a preponderance of the evidence, that the ownership interests in income are other than as provided under such subparagraphs.

"(c) RULES FOR TREATMENT OF RESOURCES.

"(1) COMPUTATION OF SPOUSAL SHARE AT TIME OF INSTITUTIONALIZATION.—There shall be computed (as of the beginning of a continuous period of institutionalization of the institutionalized spouse) a spousal share which is equal to one-half of the value of all the resources held by either the institutionalized spouse, community spouse, or both.

"(2) ATTRIBUTION OF RESOURCES AT TIME OF INITIAL ELIGIBILITY DETERMINATION.—In determining the resources of an institutionalized spouse at the time of application for benefits under this title, regardless of any State laws relating to community property or the division of marital property—

"(A) except as provided in subparagraph (B), all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse, and

"(B) resources held in the name of (or for the sole benefit of) the community spouse shall not be considered to be available to an institutionalized spouse, to the extent that the amount of such resources does not exceed the amount computed under subsection (e)(2)(A) (as of the time of application for benefits) or, if greater, the amount that a court has ordered to be retained by the community spouse for the support of the community spouse.

"(3) SEPARATE TREATMENT OF RESOURCES AFTER ELIGIBILITY FOR BENEFITS ESTABLISHED.—During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be eligible for benefits under this title, no resources of the community spouse shall be deemed available to the institutionalized spouse.

"(4) RESOURCES DEFINED.—In this section, the term 'resources' does not include resources excluded under subsection (a) or (d) of section 1613 and does not include resources that would be excluded under section 1613(a)(2)(A) but for the limitation on total value described in such section.

"(c) PROTECTING INCOME FOR COMMUNITY SPOUSE.—

"(1) ALLOWANCES TO BE OFFSET FROM INCOME OF INSTITUTIONALIZED SPOUSE.—After an institutionalized spouse is determined to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

"(A) A personal needs allowance that is reasonable in amount for clothing and other personal needs of the institutionalized spouse and which is not less than $25 per month.

"(B) A community spouse monthly income allowance (as defined in paragraph (2)), but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse.

"(C) A family allowance, for each family member, equal to at least one-third of the amount by which the amount described in paragraph (3)(A)(i) exceeds the amount of the monthly income of that family member.

"(D) Amounts for incurred expenses for medical or remedial care for the institutionalized spouse that are not subject to payment by a legally liable third party.

In subparagraph (C), the term 'family member' only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

"(2) COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE DEFINED.—In this section (except as provided in paragraph (6)), the 'community spouse monthly income allowance' for a community spouse is an amount by which—

"(A) except as provided in paragraph (4), the minimum monthly maintenance needs allowance (established under and in accordance with paragraph (3)) for the spouse, exceeds

"(B) the amount of monthly income otherwise available to the community spouse (determined without regard to such an allowance).

"(3) ESTABLISHMENT OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—

"(A) IN GENERAL.—Each State shall establish a minimum monthly maintenance needs allowance for each com-

munity spouse which, subject to subparagraph (B), is equal to or exceeds—

"(i) 150 percent of 1/12 of the nonfarm income official poverty line (defined by the Office of Management and Budget and revised annually in accordance with sections 652 and 673(2) of the Omnibus Budget Reconciliation Act of 1981) for a family unit of 2 members; plus

"(ii) an excess shelter allowance (as defined in paragraph (5)); plus

"(iii) ½ of the amount by which the income available to the institutionalized spouse exceeds the sum of the amounts described in clauses (i) and (ii).

A revision of the official poverty line referred to in clause (i) shall apply to medical assistance furnished during and after the second calendar quarter that begins after the date of publication of the revision.

"(B) CAP ON MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—The minimum monthly maintenance needs allowance established under subparagraph (A) may not exceed $1,500 (subject to adjustment under subsection (f)).

"(4) NOTICE AND FAIR HEARING.—

"(A) NOTICE.—Upon—

"(i) a determination of eligibility for medical assistance of an institutionalized spouse, or

"(ii) a request by an institutionalized spouse (or community spouse or representative on the spouse's behalf),

each State shall notify the spouse of the amount of the community spouse monthly income allowance (described in paragraph (1)(B)), of the amount of any family allowances (described in paragraph (1)(C)), of the method for computing the amount of the community spouse resources allowance permitted under subsection (e), and of the spouse's right to a fair hearing under subparagraph (B) respecting the determination of the community spouse monthly income allowance.

"(B) FAIR HEARING.—If an institutionalized spouse is dissatisfied with a determination of—

"(i) the community spouse monthly income allowance because the amount of the minimum monthly maintenance needs allowance (established under paragraph (3)) is not adequate to support the community spouse without financial duress, or

"(ii) the amount of monthly income otherwise available to the community spouse (as applied under paragraph (2)(B)),

the institutionalized spouse is entitled to a fair hearing described in section 1902(a)(3) with respect to such determination. If the institutionalized spouse establishes that the minimum monthly maintenance needs allowance is not adequate to support the community spouse without financial duress, there shall be substituted, for the minimum monthly maintenance needs allowance in paragraph (2)(A),

an amount adequate to support the community spouse without financial duress.

"(5) EXCESS SHELTER ALLOWANCE DEFINED.—In paragraph (3)(A)(ii), the term 'excess shelter allowance' means, for a community spouse, the amount by which the sum of—

"(A) the spouse's expenses for mortgage payment (including principal, interest, taxes, and insurance and, in the case of a condominium or cooperative, required maintenance charge) or rent, and

"(B) the standard utility allowance (used by the State under section 5(e) of the Food Stamp Act of 1977) or, if the State does not use such an allowance, the spouse's actual utility expenses,

exceeds 30 percent of the amount described in paragraph (3)(A)(i), except that, in the case of a condominium or cooperative, for which a maintenance charge is included under subparagraph (A), any allowance under subparagraph (B) shall be reduced to the extent the maintenance charge includes utility expenses.

"(6) COURT ORDERED SUPPORT.—If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly income so ordered.

"(e) PERMITTING TRANSFER OF RESOURCES TO COMMUNITY SPOUSE.—

"(1) IN GENERAL.—An institutionalized spouse may, without regard to section 1917, transfer to the community spouse (or to another for the sole benefit of the community spouse) an amount equal to the community spouse resource allowance (as defined in paragraph (2)), but only to the extent the resources of the institutionalized spouse are transferred to (or for the sole benefit of) the community spouse.

"(2) COMMUNITY SPOUSE RESOURCE ALLOWANCE DEFINED.—In paragraph (1), the 'community spouse resource allowance' for a community spouse is an amount (if any) by which—

"(A) the greater of—

"(i) $12,000 (subject to adjustment under subsection (f)), or

"(ii) the lesser of (I) the spousal share computed under subsection (c)(1), or (II) 4 times the amount described in clause (i), exceeds

"(B) the amount of the resources otherwise available to the community spouse (determined without regard to such an allowance).

"(3) TRANSFERS UNDER COURT ORDERS.—If a court has entered an order against an institutionalized spouse for the support of the community spouse, section 1917 shall not apply to amounts of resources transferred pursuant to such order for the support of the spouse of a family member (as defined in subsection (d)(1)).

"(f) INDEXING DOLLAR AMOUNTS.—For services furnished during a calendar year after 1988, the dollar amounts specified in subsections (d)(3)(B) and (e)(2)(A)(i) shall be increased by the same percent-

age as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between September 1987 and the September before the calendar year involved.

"(g) DEFINITIONS.—In this section:

"(1) The term 'institutionalized spouse' means an individual who—

"(A) is in a hospital, skilled nursing facility, or intermediate care facility, or who (at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI), and

"(B) is married to a spouse who is not in a hospital, skilled nursing facility, or intermediate care facility;

but does not include any such individual who is not likely to meet the requirements of subparagraph (A) for at least 30 consecutive days.

"(2) The term 'community spouse' means the spouse of an institutionalized spouse.".

(b) TAKING INTO ACCOUNT CERTAIN TRANSFERS OF ASSETS.—Subsection (c) of section 1917 (42 U.S.C. 1396p) is amended to read as follows:

"(c)(1) In order to meet the requirements of this subsection (for purposes of section 1902(a)(49)(B)), the State plan must provide for a period of ineligibility in the case of an institutionalized individual (as defined in paragraph (3)) who, at any time during the 24-month period immediately before the individual's application for medical assistance under the State plan, disposed of resources for less than fair market value. The period of ineligibility shall begin with the month in which such resources were transferred and the number of months in such period shall be equal to (A) the total uncompensated value of the resources so transferred, divided by (B) the average cost, to a private patient at the time of the application, of nursing home care in the State or, at State option, in the community in which the individual is institutionalized.

"(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

"(A) the resources transferred were a home and title to the home was transferred to the individual's spouse or child who is under age 21, or (with respect to State eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614;

"(B) the resources were transferred to (or to another for the sole benefit of) the community spouse, as defined in section 1921(g)(2);

"(C) a satisfactory showing is made to the State (in accordance with any regulations promulgated by the Secretary) that the individual intended to dispose of the resources either at fair market value, or for other valuable consideration; and

"(D) the State determines that denial of eligibility would work an undue hardship.

"(3) In this subsection, the term 'institutionalized individual' means an individual who—

"(A) is an inpatient in a skilled nursing facility, intermediate care facility, or other medical institution and

"(B) is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

"(4) A State may not provide for any period of ineligibility for an institutionalized individual due to transfer of resources for less than fair market value except in accordance with this subsection.".

(c) CONFORMING AMENDMENT.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (10)(C)(i)(III), by striking "the same" each place it appears and inserting "no more restrictive than the";

(2) by striking "and" at the end of paragraph (46);

(3) by striking out the period at the end of the paragraph (47) inserted by section 9407(a) of the Omnibus Budget Reconciliation Act of 1986 and inserting a semicolon;

(4) in the paragraph (47) added by section 11005(b) of the Anti-Drug Abuse Act of 1986, by redesignating such paragraph as paragraph (48), by transferring and inserting such paragraph immediately after paragraph (47), and by striking the period and inserting "; and";

(5) by inserting after paragraph (48) the following new paragraph:

"(49)(A) meet the requirements of section 1921 (relating to protection of community spouses), and (B) meet the requirement of section 1917(c) (relating to transfer of assets).";

and

(6) by adding at the end the following new sentence: "For purposes of paragraph (10), methodology is considered to be 'no more restrictive' if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.".

(d) EFFECTIVE DATE.—(1) The amendments made by this section apply (except as provided under paragraphs (2) and (3)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after January 1, 1988, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

(3) The amendments made by subparagraphs (A) and (F) of subsection (c)(1) shall apply to medical assistance furnished on or after October 1, 1982.

SEC. 215. STUDY OF ADULT DAY CARE SERVICES.

(a) SURVEY OF CURRENT ADULT DAY CARE SERVICES.—The Secretary of Health and Human Services shall conduct a survey of adult day care services in the United States to collect information concerning—

(1) the scope of such services and the extent of their availability;

(2) the characteristics of entities providing such services;

(3) licensure, certification, and other quality standards that are applied to those providing such services;

(4) the cost and financing of such services; and

(5) the characteristics of the people who use such services.

(b) REPORT.—The Secretary shall report to Congress, by not later than 1 year after the date of the enactment of this Act, on the information collected in the survey. Based on such information, the Secretary shall include in the report recommendations concerning appropriate standards for coverage of adult day care services under medicare, including defining chronically dependent individuals, defining services included in adult day care services, establishing qualifications of providers of adult day care services, and establishing a reimbursement mechanism.

(c) ADULT DAY CARE SERVICES DEFINED.—In this section, the term "adult day care services" means medical or social services provided in an organized nonresidential setting to chronically impaired individuals who are not inpatients in a medical institution.

TITLE III—UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

SEC. 301. ESTABLISHMENT.

There is established a commission to be known as the United States Bipartisan Commission on Comprehensive Health Care (in this Act referred to as the "Commission").

SEC. 302. DUTIES.

(a) IN GENERAL.—The Commission shall—

(1) examine shortcomings in the current health care delivery and financing mechanisms that limit or prevent access of all individuals in the United States to comprehensive health care, and

(2) make specific recommendations to the Congress respecting Federal programs, policies, and financing needed to assure the availability of—

(A) comprehensive long-term care services for the elderly and disabled,

(B) comprehensive health care services for the elderly and disabled, and

(C) comprehensive health care services for all individuals in the United States.

(b) CONSIDERATIONS IN RECOMMENDATIONS.—In making its recommendations, the Commission shall consider—

(1) the amount and sources (consistent with principles of social insurance) of Federal funds to finance the needed services, including reallocations of existing Federal program funds, and

(2) the most efficient and effective manner of administering such programs.

(c) DEFINITIONS.—In this title:

(1) The term "comprehensive health care services" includes—

(A) inpatient hospital services (including mental health services);

(B) skilled nursing facility services, intermediate care facility services, home health services, and other long-term health care services;

(C) physician services and other outpatient health care services (including mental health services);

(D) periodic general physical examinations, eye examinations, hearing examinations, dental examinations, foot examinations, and other preventive health care services; and

(E) prescription drugs, eyeglasses, hearing aids, orthopedic equipment, and dentures (both complete and partial).

(2) The term "comprehensive long-term care services" includes custodial and noncustodial services in facilities, as well as home and community-based services.

SEC. 303. MEMBERSHIP.

(a) APPOINTMENT.—The Commission shall be composed of 15 members appointed as follows:

(1) The President shall appoint 3 members.

(2) The President Pro Tempore of the Senate shall appoint, after consultation with the minority leader of the Senate, 6 members, of whom not more than 4 may be of the same political party.

(3) The Speaker of the House of Representatives shall appoint, after consultation with the minority leader of the House of Representatives, 6 members of the House, of whom not more than 4 may be of the same policital party.

(b) CHAIRMAN AND VICE CHAIRMAN.—The Commission shall elect a chairman and vice chairman from among its members.

(c) VACANCIES.—Any vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made and shall not affect the power of the remaining members to execute the duties of the Commission.

(d) QUORUM.—A quorum shall consist of 8 members of the Commission, except that 4 members may conduct a hearing under section 305(a).

(e) MEETINGS.—The Commission shall meet at the call of its chairman or a majority of its members.

(f) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—Members of the Commission are not entitled to receive compensation for service on the Commission. Members may be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Commission.

SEC. 304. STAFF AND CONSULTANTS.

(a) STAFF.—The Commission may appoint and determine the compensation of such staff as may be necessary to carry out the duties of the Commission. Such appointments and compensation may be made without regard to the provisions of title 5, United States Code, that govern appointments in the competitive services, and the provisions of chapter 51 and subchapter III of chapter 53 of such title that relate to classifications and the General Schedule pay rates.

(b) CONSULTANTS.—The Commission may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Commission determines to be necessary to carry out the duties of the Commission.

SEC. 305. POWERS.

(a) HEARINGS AND OTHER ACTIVITIES.—For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties.

(b) STUDIES BY GENERAL ACCOUNTING OFFICE.—Upon the request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

(c) COST ESTIMATES BY CONGRESSIONAL BUDGET OFFICE.—

(1) Upon the request of the Commission, the Director of the Congressional Budget Office shall provide to the Commission such cost estimates as the Commission determines to be necessary to carry out its duties.

(2) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under paragraph (1).

(d) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(e) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties.

(f) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies.

(g) OBTAINING INFORMATION.—The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 5, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

(h) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to

the Commission on a reimbursable basis such administrative support services as the Commission may request.

(i) ACCEPTANCE OF DONATIONS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

SEC. 306. REPORT.

(a) REPORT ON COMPREHENSIVE LONG-TERM CARE SERVICES FOR THE ELDERLY AND DISABLED.—The Commission shall submit to Congress a report, not later than 6 months after the date of the enactment of this Act, containing its findings and recommendations regarding comprehensive long-term care services for the elderly and disabled. The report shall include detailed recommendations for appropriate legislative initiatives respecting such services.

(b) REPORT ON COMPREHENSIVE HEALTH CARE SERVICES.—The Commission shall submit to Congress a report, not later than 1 year after the date of the enactment of this Act, containing its findings and recommendations regarding comprehensive health care services for the elderly and disabled and comprehensive health care services for all individuals in the United States. The report shall include detailed recommendations for appropriate legislative initiatives respecting such services.

SEC. 307. TERMINATION.

The Commission shall terminate 30 days after the date of submission of the report required in section 306(b).

SEC. 308. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated $1,500,000 to carry out this title.

PURPOSE AND SUMMARY

The purpose of H.R. 2470 is to protect the elderly and disabled population from the financial disaster caused by catastrophic health care expenditures not currently reimbursed under the Medicare and Medicaid programs. The bill would substantially reduce the required cost sharing under Medicare, would require the States to extend eligibility under Medicaid, and would enhance the benefits covered under both programs.

The bill has three titles. Title one restructures and simplifies the coverage rules for Part A of Medicare and establishes an income-related supplemental premium which will raise revenues equal to or greater than the cost of the bill's Medicare improvements. Medicare enrollees needing inpatient hospital care would pay only one hospital deductible per year. The bill would eliminate the "spell of illness" concept, as well as the current-day limitations and coinsurance requirements on inpatient hospital stays. The skilled nursing home benefit would also be revamped. The requirement of a three day prior hospital stay would be eliminated, the days covered would be extended from 100 to 150 days, and the coinsurance would be changed to require enrollees to pay 20% of the national average per diem cost for each of the first seven days. Coverage of hospice care would be extended and the blood deductible requirements reduced. In addition, the current rule that home health benefits should be paid under Part A for patients enrolled in both Part A

and Part B would be reversed, so that payment in those circumstances would be made under Part B.

The income-related supplemental premium would be collected by the Internal Revenue Service as part of the income tax system. Individuals entitled to Part A of Medicare would pay an amount based on adjusted gross income and determined according to a table included in their tax forms.

Title II contains improvements in Part B of Medicare. It would establish an upper limit on the amount of cost sharing a Part B enrollee would be required to pay each year. After an enrollee had met the limit, Medicare would pay 100% of the reasonable charge (or reasonable cost) for any subsequent Part B services. The limit would be $1043 in 1989, and would increase by the Social Security COLA in the following years.

Title II would also provide Medicare coverage for outpatient prescription drugs, subject to a $500 annual deductible, and would provide up to 120 hours per year of home health aide and personal care services for chronically dependent individuals, living with a primary caregiver, who cannot be left alone in their homes. Both of these new benefits would be financed with enrollee premiums. The existing home health benefit would be made available on a daily basis for up to 35 days, and the existing limitation on payments for outpatient mental health treatments would be increased from $250 per year to $1000 per year. Medicare coverage would be extended to influenza vaccines, without any deductible or coinsurance. All Part B enrollees would pay an additional premium of $1 per month in 1990 and $1.50 per month in 1991 and 1992 (plus the additional monthly premiums needed to finance the prescription drug, in-home care, and flu vaccine benefits added by the bill.) All enrollees would be sent an annual notice explaining the benefits and limitations of the Medicare program and would receive a directory of participating physicians for their area.

States would be required to pay the Medicare premiums, deductibles and coinsurance for all Medicare enrollees with incomes at or below the Federal poverty guideline and assets at or below twice the Supplemental Security Income guidelines. States would also have to allow the spouse, living at home, of a medicaid-eligible nursing home resident to retain at least $925 per month in income and at least $12,000 in assets. Finally, States would be required to delay Medicaid eligibility to individuals who transfer countable resources for less than fair market value within two years of application for Medicaid benefits.

Title II would also require conforming changes in the requirements for Medicare supplemental policies, would extend the existing Medicare demonstration projects for social health maintenance organizations, would require a study of comprehensive health care coverage by the General Accounting Office, and would require the Secretary of Health and Human Services to conduct research on long-term care and a study of adult day care.

Title III would establish 15 member Bipartisan Congressional Commission to report within 6 months on expanding long-term care services under Medicare and within 12 months on providing comprehensive health care for all Americans.

Background and Need for Legislation

When Medicare was enacted in 1965, it was patterned after private health insurance policies generally available at that time. Although there have been marginal changes and improvements in the program over the last 22 years, the basic structure and benefits of the program have remained intact. During those 22 years, however, there have been extraordinary changes in health care technology and the delivery of health care services. In addition, the costs of health care have been rising at an accelerating pace. As a result, the Medicare program has been covering a decreasing proportion of the health care needs and costs of its enrollees.

The Medicare progam provides reasonable protection for short term acute hospital stays and for other acute care. However, its protections are less adequate for those enrollees with chronic conditions or extended hospital stays, or in need of long-term care.

Today, Medicare pays only 45% of the health care expenditures incurred by the elderly. Yet, the elderly incur, on average, three times the health care costs incurred by the nonelderly. The elderly are paying as much of their income, on average, for health care now as they spent the year before Medicare was enacted. Many of the elderly cannot afford these expenses. According to Congressional Budget Office testimony at a hearing of the Subcommittee on Health and the Environment, held on March 26, 1986, over 12 percent of the elderly have incomes below poverty and over 20 percent have incomes below 125% of poverty.

Many Medicare enrollees seek additional protection against the costs of health care. About 9% are eligible for Medicaid, and have their Medicare premiums and cost-sharing paid by Medicaid. However, nearly a third of those enrollees with incomes below the Federal poverty guidelines are not eligible for Medicaid, because of restrictive eligibility criteria. Over two-thirds of Medicare enrollees purchase Medicare supplemental policies—or Medigap—at an average cost of over $500 per year. These policies cover most of the cost-sharing for Medicare covered services, but they do not typically cover additional benefits, and their administrative costs frequently exceed 40% of premiums, in contrast to the 2.5% of Medicare outlays that go for administration of the program. Roughly 20% of Medicare enrollees have no additional coverage, principally because they cannot afford Medigap and do not qualify for Medicaid.

The elderly population is projected to grow substantially over the next several years, particularly those over age 75 and age 85. Many of these elderly will suffer chronic conditions and will be vulnerable to the catastrophic costs of health care. They will be at risk not only for the cost-sharing on Medicare covered services, but also for the costs of services not covered by Medicare. Two notable gaps in the Medicare program, identified by elderly constituency groups as being priority concerns, are outpatient prescription drugs and long-term care.

All of these factors and concerns have led to a growing awareness among members of the Committee and the general public that the benefit limitations, gaps in coverage, cost-sharing requirements, and obscure coverage rules of the Medicare program are in need of re-examination and revision. Medicare enrollees are in dire

need of better protection against the financial devastation of catastrophic health care expenditures.

Explanation of Legislation

Title I—Provisions Relating to Part A of Medicare

Title I of H.R. 2470 is not within the jurisdiction of the Committee and was not amended. The following explanation of Title I, as reported by the Committee on Ways and Means on May 19, 1987, is included to provide a complete report.

Inpatient hospital services (section 101)

Under current law, beneficiaries are required to pay a first day deductible for inpatient hospital services furnished in each "spell of illness". (A "spell of illness" is a period of consecutive days that begins with the first day on which a patient is furnished inpatient hospital or extended care services and ends with a period of 60 consecutive days during which the beneficiary was not an inpatient of either a hospital or a skilled nursing facility. A beneficiary may be discharged from and readmitted to a hospital or skilled nursing facility several times during a "spell of illness" and still be in the same spell, if 60 days have not elapsed between discharge and readmission.) The inpatient hospital deductible is $520 in 1987.

A beneficiary is entitled to inpatient hospital services for up to 90 days in any one spell of illness. In addition to the 90 days of hospital care, each beneficiary has a lifetime reserve of 60 days of added coverage after the 90 days have been exhausted. After a beneficiary has received 90 days of care in a spell of illness and exhausted the 60 lifetime reserve days, Medicare does not provide for further hospital reimbursement and the beneficiary is responsible for all hospital charges.

Beneficiaries are also required to pay coinsurance when inpatient hospital services are received for more than 60 days during a spell of illness. The beneficiary is responsible for a coinsurance amount for each day after the 60th and through the 90th day, equal to one-fourth of the inpatient hospital deductible ($130 a day in 1987). There is also a coinsurance amount for each day that is chargeable against the individual's 60 lifetime reserve days. The coinsurance for these days by law is equal to one-half of the inpatient hospital deductible ($260 a day in 1987).

Under current law, the amount of the hospital deductible is revised each January and is equal to the inpatient hospital deductible for the preceeding calendar year, updated by the same percentage that applies to prospective payment (PPS) rates and adjusted to reflect changes in real case mix.

Individuals age 65 or over who are not entitled to Hospital Insurance (Part A) benefits may voluntarily enroll in the Hospital Insurance program if they pay a monthly premium. The premium currently does not reflect the actuarial value of the Hospital Insurance benefit. Instead, the Secretary is required to calculate the premium each year under a formula that is equal to $33 multiplied by the ratio of the inpatient hospital deductible for the subsequent calendar year to the deductible promulgated for 1973.

This bill would make several changes in these provisions. A beneficiary would be required to pay only one hospital deductible in a calendar year no matter how many times the beneficiary was admitted to a hospital during the calendar year. The "spell of illness' methodology would be eliminated for determining the number of hospital deductibles, ther number of days Medicare would cover, and the hospital coinsurance amounts. A new deductible would not be required if the hospitalization began in one calendar year and continued into the following year, but a deductible would be required if the beneficiary reentered the hospital later in the second year.

The Medicare limits on payment for 150 days of inpatient hospital care would be eliminated, so that Medicare would pay for an unlimited number of hospital days for covered services in a calendar year. (However, the current 190 day lifetime limit and 150 day rule on inpatient psychiatric hospital services would be retained.) The current requirement for the payment of hospital coinsurance amounts for inpatient days 61 through 90 and the 60 lifetime reserve days would also be eliminated.

The method of determining the inpatient hospital deductible beginning in 1988 would be changed so that it would equal the preceding year's deductible, increased by the cost-of-living adjustment of Social Security benefits. Not later than November 15 of each year, beginning in 1987, the Secretary would be required to promulgate the inpatient hospital deductible for the succeeding year.

The Secretary would be required to establish a monthly Part A premium equal to the actuarial value of the Part A benefit for those who voluntarily enroll in Part A. The actuarial value would equal one-twelfth of the estimated average annual per capita amount payable from the Hospital Insurance Trust Fund for services and related administrative costs incurred in the succeeding calendar year for individuals age 65 and over entitled to hospital benefits during that entire year. The Secretary would be required to determine and promulgate during September of each year and issue a public statement setting forth the actuarial assumptions and basis employed in determining the actuarial rate.

When adjustment payments under the Medicare hospital prospective payment system, the Secretary would be required to take into account the reductions in beneficiary payments to hospitals because of the elimination of the day limitation. The Secretary, when appropriate, would adjust the payment rates under the prospective payment system (PPS), the outlier cutoff points, the weighting factors, and the target amounts for paying non-PPS hospitals.

The changes relating to the deductible would be effective for inpatient hospital services furnished on or after January 1, 1988, and succeeding years. However, in the case of an individual for whom a "spell of illness" began before January 1, 1988, and had not yet ended as of such date, the deductible would not apply to services furnished during that spell of illness during 1988 or 1989.

The changes relating to the extension of benfits and coinsurance would be effective for inpatient hospital services furnished on or after January 1, 1988.

The changes relating to the Part A premium would apply to premiums for months beginning with January 1, 1988.

The Secretary, when appropriate, would adjust inpatient hospital payments to hospitals for services furnished on or after January 1, 1988.

Extended care services (section 102)

Under current law, a beneficiary is responsible for a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day after the 20th and before the 101st day of extended care services furnished during a "spell of illness". This coinsurance amount is $65 a day in 1987. A beneficiary is entitled to post-hospital extended care services in a qualified skilled nursing facility for up to 100 days in any one spell of illness, but the services in a skilled nursing facility are covered under Medicare only after an individual has been transferred to the facility from a hospital in which the individual was a patient for not less than three consecutive calendar days.

Under the bill, a Medicare beneficiary would be required to pay coinsurance amounts for the first 7 days of covered services in a calendar year. The coinsurance amount for each day would equal 20 percent of the national average per diem Medicare reasonable cost for SNF services in the succeeding calendar year, as estimated by the Secretary each year. The Secretary would, in September of each year (beginning in 1987), promulgate the coinsurance amount which shall apply to post-hospital extended care services furnished in the succeeding year.

The Medicare program would cover up to 150 days of post-hospital extended care services furnished during a calendar year. The three day prior hospitalization requirement to receive extended care services in a skilled nursing facility would be eliminated.

The coinsurance and extension of days would be effective for services furnished on or after January 1, 1988. The elimination of the three day hospital requirement would become effective for skilled nursing facility stays beginning on or after January 1, 1989.

Hospice care (section 103)

Under current law, a beneficiary who is terminally ill is entitled to elect to receive hospice care for two periods of 90 days and one subsequent period of 30 days, for a total of 210 days of hospice care. In order to receive the hospice benefit, the beneficiary's attending physician and the medical director (or staff physician) of the hospice program must certify, not later than two days after hospice care in initiated, that the beneficiary is terminally ill (i.e. that the beneficiary has a medical prognosis that his life expectancy is six months or less). If the beneficiary elects to receive hospice care for a second or third period, the medical director must recertify at the beginning of that period that the beneficiary is terminally ill.

Under the bill, a Medicare beneficiary would be entitled to a subsequent extension of the hospice benefit after the 210 day limit, if he or she was recertified as terminally ill by the attending physician or medical director.

These changes would be effective for hospice care furnished on or after January 1, 1988.

Blood deductible (section 104)

Under current law, a beneficiary is required to pay a separate deductible equal to the cost of the first three pints of whole blood (or equivalent quantities of red blood cells) received by a beneficiary as part of the services furnished under the hospital insurance (Part A) program during each "spell of illness." There is also a separate deductible under Part B of Medicare equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of red blood cells) furnished to a beneficiary during a calendar year.

In keeping with the elimination of the "spell of illness" concept for hospital services, it is necessary to conform the blood deductible rules and eliminate the spell of illness concept for the blood deductible.

A Medicare beneficiary would be responsible for payment of a deductible equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells) furnished each calendar year, except that the deductible for such blood would be reduced appropriately, in accordance with regulations developed by the Secretary of Health and Human Services, to the extent that there had been a replacement of such blood. The Secretary is directed to utilize the same replacement requirements that are currently used for the Part B blood deductible replacement requirements.

A Medicare beneficiary would be required to pay only one blood deductible in a calendar year under Parts A or B.

These changes would be effective for blood or packed red blood cells furnished on or after January 1, 1988.

Home health benefits (section 105)

Under current law, home health care is a covered benefit under both Medicare Part A and Part B. Eligibility and reimbursement policies are identical under both parts. There is no coinsurance or deductible payment requirement for home health under either Part A or Part B, and there is no limit on the number of home health visits covered by Medicare.

Payment for home health care, however, is currently made from the Part A trust fund for all home health services except for those provided to individuals enrolled under Part B, but not entitled to receive benefits under Part A. Only about 1 percent of home health is reimbursed under Part B.

Under current law, the Part B premium is set at 25 percent of total Part B program costs. Beginning in 1989, the Part B premium will be set at the lower of (1) an amount sufficient to cover one-half of the costs of the program, or (2) the current premium amount increased by the percentage by which cash benefits were increased under the Social Security cost of living adjustment (COLA).

Under the bill, beginning with fiscal year 1989, home health care would no longer be a covered benefit under Medicare Part A, except for individuals eligible for benefits under Part A who have not enrolled under Part B. Those individuals would continue to be eligible for home health benefits under part A. Individuals enrolled

under Part B would only be entitled to receive home health benefits under Part B.

There would be no change in coverage or reimbursement policies for home health services. There also would be no change in the Part B premium as a result of this provision: the 1989 premium would be based on the 1988 premium increased by the Social Security COLA.

This provision would be effective for home health services furnished on and after January 1, 1989.

Supplemental premium (section 106)

Under current law, individuals who have attained age 65 and who are eligible for monthly social security or railroad retirement cash benefits are eligible, without additional application, for coverage under the Hospital Insurance (Part A) program of Medicare without any payment for the coverage. Eligibility for Part A coverage begins with the first day of the month in which an individual attains age 65. Entitlement ends with the earlier of the last day of the month of death or the last day of the month before the month in which the beneficiary no longer meets the requirements for entitlement to social security, railroad retirement, or survivor benefits.

Part A coverage also is available, without payment of the Part A premium, to individuals under age 65 who have been entitled for not less than 24 months to social security or railroad retirement benefits on the basis of disability. This entitlement for Part A coverage applies to qualified railroad retirement disability beneficiaries and the following categories of social security beneficiaries: disabled workers, disabled widows and widowers between the ages of 50 and 65, certain women age 50 or older entitled to mother's benefits, and individuals age 18 and over who receive social security benefits because they became disabled before reaching age 22. Entitlement to Part A begins with the first day of the 25th month of entitlement to social security or railroad retirement benefits on the basis of disability. Such entitlement to Part A continues until the end of the month following the month in which notice of the termination of disability status is mailed to the beneficiaries, or, if earlier, with the end of the month before the month in which the beneficiary attains age 65.

Further, Part A coverage is available, without payment of the Part A premium, to individuals, even though they have not reached age 65, who have end-stage renal disease (i.e., kidney impairment that appears irreversible and permanent and requires either a regular course of dialysis or kidney transplantation to maintain life). End-stage renal disease Medicare benefits are available only after an application for Medicare benefits is filed.

Under the bill, an individual (other than certain individuals described below) who is eligible in any year for Medicare Part A coverage by reason of eligibility for social security, railroad retirement, disability, or end-stage renal disease benefits, and who is not required to pay the Part A premium, would be required to pay a supplemental premium based on the individual's adjusted gross income (AGI) for that year. The premium would be paid and collected in the same manner as an income tax.

The amount of the premium would be determined according to a table setting forth specified annual premiums for adjusted gross income brackets over $6,000. The table for taxable year 1988 is set forth in the bill. The minimum premium in 1988 is $10 and the maximum is $580.

The annual premium determined under this table would be prorated based on the number of months an individual is a medicare-eligble individual during the taxable year. The same rule is to apply in the case of a short taxable year, except that in such case, the individual's gross income would be annualized (assuming that the individual would have received adjusted gross income at the same rate for a full 12 months.)

In the case of a joint return, the premium table would be applied separately to each spouse who is a Medicare-eligible individual. For this purpose, the AGI of each spouse would be deemed to be one-half of the couple's combined AGI under the joint return.

By December 15 of each year, beginning in 1988, the Secretary would prescribe an adjusted table applicable to taxable years beginning in the immediately succeeding calendar year. The Secretary would adjust the premium amounts by the Medicare inflation factor. The other dollar amounts would be adjusted by the cost-of-living adjustment applicable to such year for purposes of the income tax brackets. Adjustments of amounts in the table would be rounded to the nearest dollar.

The Medicare inflation factor for any calendar year would be the percentage (if any) by which the Medicare value for such year exceeds the Medicare value for 1988. The Medicare value for any year is essentially the sum of (1) 50 percent of the value of Part A coverage, and (2) 75 percent of the value of Part B coverage.

Generally, an individual would be a "Medicare-eligible individual," and therefore would be responsible for the supplemental premium, if such individual is entitled to (or, on application, with no payment, would be entitled to) Part A coverage. An individual, other than a nonresident alien, would be treated as a Medicare-eligible individual for the month in which he attained age 65 and any subsequent month, unless such individual established to the satisfaction of the Secretary that he was not a Medicare-eligible individual for such month.

An individual would not be a "Medicare-eligible individual" for any month for which he was (1) entitled to benefits solely because he paid a Part A premium; (2) a resident of a U.S. possession who paid the extra Part B premium applicable only to such residents (see section 209, below); or (3) a qualified nonresident, as defined in the bill. The exemption for Part A enrollees who pay the Part A premium is based on the fact that such enrollees would have already paid for the full cost of Part A coverage. The residents of United States possessions would be exempted because they would have paid an additional part B premium for the new would be catastrophic benefits. Qualified nonresidents are viewed as, in effect, not receiving coverage under Part A and thus should be exempt from the supplemental premium.

For purposes of the rules regarding payment (including estimated payment) and collection of taxes, the supplemental premium would be considered an income tax.

It would not, however, be considered an income tax for purposes of determining either the amount of any credits allowable against income tax or the alternative minimum tax. Section 15 of the Internal Revenue Code, relating to changes in tax rates, would not apply to the supplemental premiums. The supplemental premium would not be treated as a medical expense for purposes of section 213, which allows a deduction for medical expenses in excess of 7.5 percent of AGI.

The supplemental premium provision of the bill would be effective for taxable years beginning after December 31, 1987.

TITLE II—PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM AND TO THE MEDICAID PROGRAM

The following provisions were reported by the Committee as an amendment in the nature of a substitute for Title II, as reported by the Committee on Ways and Means.

Limitation on Medicare out-of-pocket expenses under part B (section 201)

The Supplementary Medical Insurance Program (Part B) covers physician services, hospital outpatient services, and a variety of other outpatient services, including clinical diagnostic laboratory tests, durable medical equipment, prosthetic devices, X-rays, renal dialysis, and home health services. Most of these are reimbursed on the basis of Medicare determined "reasonable charges", although some services are reimbursed on the basis of reasonable costs or according to fee schedules.

Before Medicare will start making payments, persons enrolled in Part B must pay a deductible of $75 per year, as well as an additional blood deductible for the first three pints of whole blood used in an outpatient setting during a year. In addition, for most Part B covered services, enrollees must pay coinsurance of 20% of the reasonable charge. Enrollees may also be responsible for additional out-of-pocket expenditures, if the physician or supplier of these services does not agree to take assignment of the enrollee's claim and charges the enrollee more than the Medicare program determines to be reasonable.

These expenses for cost-sharing and excess charges have grown rapidly, as the costs of health care have increased. Nearly nine percent of Part B enrollees, constituting approximately 2.8 million persons, will exceed $1000 in cost-sharing for Medicare-covered services. In addition, enrollees will be liable, on average, for nearly 30 percent more than the Medicare reasonable charge on those physician bills for which the physician does not take assignment. Medigap policies and the Medicaid program will assist many enrollees in meeting their Medicare cost-sharing obligations. However, approximately 20 percent of enrollees do not have such protection and those that do receive little or no assistance with the excess charges on non-assigned bills.

The bill would provide Part B enrollees with protection against catastrophic expenditures for cost-sharing on Medicare-covered services, by establishing a limit on such expenditures and having the program pay 100% of the reasonable charge (or reasonable

cost) for any covered services furnished during the calendar year after the limit had been met.

Expenses that would count towards the catastrophic limit would be the $75 annual Part B deductible, the Part B blood deductible, the 20% coinsurance, a maximum of $250 in cost-sharing for outpatient mental health treatments, and the reasonable expenses incurred by an enrollee for an annual colorectal examination for cancer or a triennial mammogram for detection of breast cancer. Medicare would not reimburse enrollees for the expenses of these two cancer screenings, but the expenses incurred by an enrollee would count towards the limit. The Secretary would be responsible for determining what costs were reasonable, and these would be the maximum amounts that could be counted towards the limit.

The catastrophic limit would be set at $1043 in 1989. In each succeeding year, the limit would be increased by the Social Security COLA. (The figure of $1043 for 1989 is equal to $1000 plus the projected increase in the Social Security COLA for 1989.) The Secretary would be required to publish the limit for each year by November 15 of the preceding year.

The Secretary would also be required to adjust the payments made to prepaid health care organizations, to take account of the catastrophic protections and other benefits established under this bill, which such organizations would be required to assume. The Committee expects the Secretary to make similar adjustments in the benefits covered by, and payments made to, organizations that are providing services under a prepaid capitation arrangement pursuant to a demonstration project or Medicare waiver, as appropriate to the terms and conditions of the project or waiver.

The bill would not provide an enrollee any direct financial protection against the excess charges, above those determined by Medicare to be reasonable, imposed by a physician or supplier who did not take assignment. Medicare would not pay such charges, nor would the physician of supplier be required to accept assignment. However, the bill would provide enrollees who had met the catastrophic limit with some assistance. Once an enrollee had met the catastrophic limit, if a claim were submitted on a non-assigned basis for subsequent physician services during the calendar year, the Medicare carrier would be required to notify the physician that the enrollee had already incurred sufficient out-of-pocket expenses to meet the limit. The notice to the physician would encourage the physician not to seek collection from the enrollee for amounts in excess of the Medicare reasonable charge and to accept assignment on any subsequent services during the year.

This is not expected to be an onerous task for the Medicare carriers. The carrier would already be generating a notice to the enrollee explaining its resolution of the claim, so this requirement essentially entails generating a duplicate notice to the physician, based on information that the carrier already has on hand.

The physician community has indicated on numerous occasions that physicians customarily take the patient's financial circumstances into account in deciding how much to charge and whether to take assignment. The notice called for under this provision would give the physician information about the patient that he or she might not otherwise have, bearing on the physician's decision.

It is the Committee's expectation that the physician organizations will support the implementation of this provision and will encourage their members to comply.

Coverage of catastrophic expenses for prescription drugs and insulin (section 202)

Outpatient prescription drugs that can be self-administered by the patient are not currently covered by Medicare, with the exception of immunosuppressive drugs needed by an organ transplant recipient. This gap in Medicare coverage imposes a substantial burden on enrollees. The elderly use 30 percent of all prescription drugs in this country, and use them at roughly three times the rate of the non-elderly. Many have chronic conditions that require them to take expensive medications on a regular, sustained basis in order to remain alive or to maintain their level of functioning. Nearly 5.5 million Medicare enrollees—almost 17%—incur more than $500 per year in prescription drug costs. Moreover, those who incur more than $500 in a year will average nearly $1,000 per year in drug costs. Less than half of the elderly have some form of insurance or receive some form of financial assistance with respect to the costs of these drugs, and such protection usually provides less than full coverage. National organizations representing the elderly have identified protection for these costs, along with better access to long-term care, as the highest priorities for improvements in the current Federal health care financing programs.

The Committee bill would provide catastrophic coverage for self-administered outpatient prescription drugs as a Medicare Part B benefit. The drugs that would be covered would include all those that require a prescription in order to be dispensed and are approved by the Food and Drug Administration as safe and effective. The bill would also include coverage for insulin and approved biologicals. (An existing provision of the Medicare statute would preclude payment for drugs for which the FDA has issued a notice of opportunity of hearing to withdraw the drug because it is less than effective. See section 1862(c) of the Social Security Act.) The bill would not change any current provisions under which Medicare already covers drugs, including payment for patients of skilled nursing homes, drugs provided "incident-to" a physician service, and immunosuppressive drugs.

Medicare payments would be subject to a deductible of $500 per year in 1989. In subsequent years, the deductible would be increased each year by the same percentage as the increase in the medical services component of the Consumer Price Index. This deductible would be separate and independent of the $75 Part B annual deductible and expenses incurred by the enrollee for drugs would not count toward the catastrophic limit of $1043 established in section 201 of the bill.

The enrollee would not have to show that he or she had paid these expenses out-of-pocket. If, for example, the enrollee had other insurance or was eligible for Medicaid, the expenses might be paid in whole or in part by those payers, but would still be counted toward the Medicare deductible. Once the deductible was met, there would be no further cost-sharing by the enrollee. Medicare would pay 100% of the allowed charge.

The Medicare allowed charge would be the lower of: (1) the actual charge of the dispensing pharmacist or agency, of (2) an amount established under a schedule of upper limits established by the Secretary. The limits would be established twice a year, for each drug product, and would consist of two components—one to cover the costs to the pharmacist of the drug being dispensed and the other to cover the overhead and administrative costs of the pharmacist, particularly the administrative responsibilities assumed by "participating pharmacists", as discussed below. Medicare would not pay a "dispensing fee" in addition to the allowed charge.

In calculating the limit, the Secretary would use the average wholesale price of the drug in question. Such average wholesale prices are readily available, on a national basis, from several services which compile and publish them on a monthly or quarterly basis. In the case of a brand name drug—sometimes referred to as the innovative drug or the drug which received the initial new drug application—the limit would be the average wholesale price of that drug product as of a date three months prior to the promulgation of the limit, plus an administrative allowance of $4.50. The Secretary would be instructed to calculate prices on the basis of units typically dispensed (per capsule, per tablet, or other dispensing unit) using reasonable quantities or package sizes customarily offered for sale by manufacturers and wholesalers.

These limits would normally be calculated on a nation-wide basis, but the Secretary would have authority to do so on a regional basis if he found significant variation by region in the average wholesale price or in the availability of drugs.

Limits would be set in a different manner for generic drugs. In those instances in which the FDA has approved one or more generic drugs as therapeutically equivalent to the brand name drug which received the initial new drug application, and listed the drug in its 'Orange Book" (formally entitled "Approved Drug Products with Therapeutic Equivalence Evaluations"), the Secretary would establish the limit based on the average wholesale price for the initial brand name of that drug. The Secretary would calculate 50% of the average wholesale price for the brand name, as of January 1, 1987, and would increase that amount for each six-month payment period by the percentage increase in the Consumer Price Index. The administrative allowance of $4.50 would be added to arrive at the upper payment limit.

The limit thus established for generic drugs would be the Medicare allowed charge, whenever an FDA approved generic was available, unless the prescribing physician or practitioner had specifically required that the brand name drug be dispensed. In order for Medicare to pay the higher amount for the brand name drug, the physician would have to indicate in his or her own handwriting that the brand name drug was medically necessary. The Secretary would be required to establish a particular phrase that would be used nationally, such as "Brand Medically Necessary." However, if a State currently had the same requirement for a physician's statement under its Medicaid program or under a generic substitution statute, but used a different phrase to achieve the same result, the Secretary could permit that phrase to be used in that state for pur-

poses of Medicare. However, it would have to be a written phrase, of three or more words, that reflected the physician's medical judgement that the patient's care required the brand name drug. Initials, abbreviations, preprinted signatures, or checking of preprinted forms would not satisfy the requirement. This restriction on the maximum Medicare allowable charge would be followed whenever the FDA had approved a generic drug, even if the State had not recognized that generic drug under its generic substitution policies.

The Secretary would be required to review this payment methdology and the limits described, and to report to the Congress by April 1, 1989, with any recommendations for changes or improvements. In order to prevent abusive practices in the prescribing or dispensing of drugs, the Secretary would also be authorized to establish guidelines or limitations on the frequency with which prescriptions are filled or on the maximum quantities that may be dispensed, particularly with respect to quantities dispensed at the end of a calendar year.

In order to facilitate the implementation of this new benefits, and keep program complications and administrative costs to a minimum, the bill would establish an arrangement under which pharmacists would assume significant responsibilities for assisting Medicare enrollees and Medicare carriers. Pharmacists could voluntarily sign an agreement to become a "participating pharmacy." Under the terms of the agreement, a participating pharmacy would accept assignment on all bills for drugs for Medicare enrollees who have met the $500 deductible. A participating pharmacy would also agree not to refuse to serve any Medicare enrollee and not to charge Medicare enrollees more than the charge to the general public. For this purpose, the general public would not include Medicaid patients, or subscribers of an HMO or of a insurance plan that has established discounts or special payment rules.

Additional elements of the participation agreement would include keeping patient records for all drugs dispensed to an enrollee, assisting the enrollee in determining, based on the pharmacist's records and any other records or information presented by the enrollee, whether he or she has met the $500 deductible, and filing with the Medicare carrier, on the enrollee's behalf, whatever documentation is required to establish that the deductible was met. In this regard, it is the Committee's intent that the Secretary establish a simple format and require only that information which is essential to making proper determinations and payments under the program.

A participating pharmacy would also agree to offer counsel to Medicare patients on the appropriate usage of drugs being dispensed, including possible interactions among drugs, and to advise enrollees on the availability of generics. In addition, a participating pharmacy would agree to share its records for an enrollee, at the enrollee's request, with another participating pharmacy that might be assisting the enrollee.

To facilitate this arrangement, the Secretary would be required to provide participating pharmacies with a distinctive emblem that they can display to the public and to make electronic billing available to participating pharmacies. The Secretary would also have to

notify the enrollee, and the participating pharmacy that submitted documentation on his or her behalf, whether the deductible had been met. In addition, the Secretary would be required to provide participating pharmacies with information on the payment limits prior to the start of each six-month payment period and to audit the charges of participating pharmacists to make sure that they did not exceed charges to the general public.

Medicare enrollees would not be required to choose a participating pharmacy or to obtain prescription drugs exclusively from one pharmacy. An enrollee could submit claims on his or her own behalf and could obtain prescription drugs from any pharmacist, participating or not. However, in order not to undermine the participating pharmacy program, non-participating pharmacies would not be allowed to submit claims on assignment. The Committee expects the Secretary to establish a system that would allow pharmacies to query, electronically, whether an enrollee has met the deductible.

This new benefit would he financed entirely with monthly premiums paid by all enrollees in Part B of Medicare. During September of each year, the Secretary would be required to determine the estimated aggregate costs, for both covered drugs and administration of the benefits, and the monthly premiums necessary to meet those costs. this monthly premium would be added to the monthly premium for Part B otherwise determined under the statute. Although this new provision would not be effective until January 1, 1989, the Health Care Financing Administration, and the Medicare carriers, would incur administrative costs in 1988 in preparing for implementation the following year. These administrative costs would also be financed by monthly premiums.

The committee bill would set an upper limit on the monthly premiums that could be set by the Secretary for each of the first three years. The Committee is concerned about differences in the cost estimates prepared by the Congressional Budget Office and by the Department of Health and Human Services. The limits on monthly premiums set forth in the bill are based on the most recent cost estimates available to the committee at the time it reported the bill. It is the committee's intent, however, that the provision be fully financed by premiums. The bill, therefore, includes special provisions to make sure that this occurs, while also protecting enrollees from large increases in their monthly premiums due to increases in the cost of the benefit beyond those currently projected.

As indicated above, the Secretary would be required to estimate the total costs of the benefit and calculate the monthly premium necessary to meet those costs. Beginning with the calculation of the monthly premiums for 1991, the Secretary would have to include in the estimated costs of the benefit any surplus or shortfall in the premium revenues for the preceding years, and calculate a monthly premium sufficient to account for such surplus or shortfall.

The premium, however, would not be allowed to increase in any year by more than 20 percent over the amount of the premium in the prior year, beginning again with respect to premiums for 1991. If the Secretary's estimate of the premium needed to finance the benefit indicated an increase of more than 20 percent over the prior year, the Secretary would be required to increase the deducti-

ble by an amount sufficient to reduce the total costs of the program to a level that would be fully financed by a 20 percent increase in the premium. This calculation would be done each year, beginning in 1991. If the deductible were increased under this provision in one year, it would not necessarily remain at the higher level in subsequent years. the Secretary would initiate the estimate of the total costs of the program in subsequent years, using the deductible that would otherwise be in effect in the absence of the increase needed in the prior year. If the estimate again indicated that a premium increase of 20 percent was not adequate to meet the costs of the benefit, the deductible would then again be increased as necessary to contain costs within the available financing.

For poor Medicare beneficiaries—those with incomes of less than $458 per month—a $500 annual deductible on prescription drug coverage represents a major financial burden. Under current law, most States pay Medicare Part B premiums and other cost-sharing for their elderly and disabled Medicaid beneficiaries. Due to restrictive income and resource standards used by State Medicaid programs, however, there are significant numbers of elderly and disabled with incomes below the poverty line who are not eligible for Medicaid and have to pay all of the Medicare cost-sharing requirements out-of-pocket.

The Committee notes that enactment of the Medicare drug benefit in this bill would result in significant savings to State Medicaid programs, almost all of which now offer prescription drug benefits to low-income elderly and disabled beneficiaries. If an individual who is eligible for both Medicare and Medicaid satisfies the $500 deductible, the Medicare program would cover all drug costs that the State now covers through its Medicaid program. In the view of the Committee, it is appropriate to require the States, in effect, to reinvest these savings in supplementing Medicare drug coverage for all their low-income elderly and disabled, not just those who are currently eligible for Medicaid.

The Committee bill would require States, through their Medicaid programs, to cover both the Medicare Part B premium (including any increment attributable to the prescription drug benefit), as well as the $500 prescription drug deductible, for all elderly and disabled Medicare beneficiaries with incomes below 100 percent of the Federal poverty guidelines and countable resources of up to twice the level permitted by the Supplemental Security Income (SSI) program ($3600 in 1987). The purpose of this provision, which parallels the general Medicaid "buy-in" requirement found at section 208 of the Committee bill, is to assure effective protection against catastrophic drug costs for poor Medicare beneficiaries.

With respect to coverage of the deductible, the bill would give the States two options. A State could either offer the Medicare beneficiary the same prescription drug benefit that it offers to its categorically needy Medicaid eligibles until the deductible is satisfied and Medicare coverage begins. Or, it could simply reimburse the beneficiary directly for the charges incurred for prescription drugs up to $500. Whatever method the State selects must apply to all qualified Medicare beneficiaries. If the State elected to offer its Medicaid prescription drug benefit, the calculation of whether the Medicare deductible had been satisfied would have to be based on

the actual charges for the drugs used, not on the amounts that the State actually reimbursed for the drugs through its Medicaid program.

State expenditures for Medicare prescription drug premiums and deductibles would be subject to Federal Medicaid matching payments at the State's regular matching rate for services. This buy-in requirement would, on July 1, 1988, take effect whether or not implementing regulations have been issued. Thus, States would begin paying the monthly Part B premium increments beginning July 1988, and would begin assisting qualified beneficiaries to meet the deductible with respect to drugs dispensed on or after January 1, 1989.

The provision would be effective, with regard to Medicare payments for prescription drugs, on January 1, 1989.

In-home care for certain chronically dependent individuals (section 203)

Among the Nation's elderly population, 3.6 million people (13 percent) live in the community and are disabled in some essential activities of daily living, such as eating, toileting, and moving from place to place. Over two-thirds of these individuals require considerable help to remain at home and in the community. According to the Congressional Budget Office, approximately 500,000 of them are so chronically impaired that they are unable to perform at least three activities of daily living without assistance. The nature of their impairments means that they need help everyday and they cannot be left alone.

Today, 80 percent of the most chronically dependent elderly live in a community setting. They neither reside nor receive care in a nursing home. Seventy-five percent of these individuals are able to stay at home and in the community because they have a primary caregiver—usually a spouse or child—who provides virtually all of their care. Without this assistance, these severely impaired individuals would have to be placed in a nursing home—at a greater cost—where they could receive the constant care and supervision they require.

In order to maintain this level of assistance and, in turn, to allow those who are chronically dependent to remain at home, the Committee bill would supplement the current Medicare home health benefit with certain limited and less skilled services for this population. Such medically-related services would be provided through Medicare certified home health agencies and would be offered in addition to, and not as an alternative to, current home health benefits under Medicare. Moreover, the Committee would establish separate conditions for eligibility for these services and not mandate that individual meet the requirements now in place for Medicare home health benefits.

The Committee intends the in-home benefit to provide limited assistance to those with chronic impairments who cannot live alone in the community. To qualify for such in-home care, a Medicare beneficiary would have to be unable to carry out two or more of the activities of daily living specified in the legislation (eating, bathing, dressing, toileting, and transferring in and out of a bed or in and out of a chair) without the assistance of a primary caregiver

who is living with the beneficiary. Individuals requiring such assistance would include those with cognitive impairments, such as those affecting people with Alzheimer's disease.

To be eligible for this new benefit, Medicare enrollees would have to be receiving assistance with respect to these designated activities, although help (either skilled or non-skilled) may also be provided (by the caregiver or other individuals under private insurance or publicly-financed programs) to meet different, additional health care needs. Moreover, assistance with these designated activities would have to be given on a daily basis for at least a three month period prior to the time coverage could begin. In addition, assistance would have to be provided by a caregiver who (1) is actually living with the beneficiary in a place of residence which both individuals use as a home; and (2) does not receive monetary compensation for the services he or she furnishes. This requirement is intended to exclude coverage for individuals whose care is provided by a paid employee of the beneficiary or his or her family. A physician's certification that these conditions were met would be required before eligibility for in-home care could be established.

Once eligibility is established, a beneficiary could receive up to 120 hours of in-home services during the remainder of the calendar year following physician certification. Services to be offered include homemaker or home health aide, personal services, and nursing care provided by a licensed practical nurse. These services could be furnished only in the beneficiary's home and must be delivered under the supervision of a registered professional nurse by (or through contract agreements or other appropriate arrangements with) a Medicare certified home health agency. The Committee bill would place no restrictions on the number of hours that may be consumed for each type of service that would be offered as part of the in-home care benefit. Thus, beneficiaries would be able to receive any or all of the three types of in-home care services specified in the legislation, so long as the total number of hours of services paid by Medicare does not exceed 120 in a calendar year.

In determining whether the 120 hour per year limitation has been met, in-home care that is provided for less than 3 hours on any individual day would be counted as 3 hours of such services. Payment for such services, however, would be made only on the basis of the actual amount of time spent in the provision of care. Medicare would pay 80 percent of the reasonable cost for the services provided and beneficiaries would pay 20 percent coinsurance, in the same manner as other Part B services. Thus, a beneficiary who receives 2 hours of homemaker services during a day would be considered to have received 3 hours of such care that would be applied against the total limitation of 120 hours, but the home health agency that provided the services would be paid only for the 2 hours of care that was actually given. Medicare would cover 80 percent of the reasonable cost for the 2 hours of services; the beneficiary would make a 20 percent coinsurance contribution. The Committee believes these procedures will help maximize its cost-effectiveness.

The costs of the in-home care benefit would be financed entirely through an increase in the premium that is paid by all individuals enrolled in Part B of the Medicare program. The additional

amount of the premium to pay for in-home care could not, however, exceed 40 cents in 1989, the first year of the program, and 70 cents in 1990. In subsequent years, the additional amount of the premium could not exceed 20 percent of the additional premium for the previous year. If revenues greater than those resulting from a 20 percent increase in premiums are needed in these years to finance the benefit completely, the Secretary would be required to reduce the maximum number of hours (120) to which a chronically dependent beneficiary would be entitled to in-home care. Further increases beyond the 20 percent of the additional premium for the previous year would be prohibited.

In order to evaluate this in-home care benefit, the Committee bill would require that the Secretary study and report on the extent of use, the cost, and the effectiveness of such care provided to chronically dependent individuals. The report would be made to the Congress no later than January 1, 1991. The Committee notes that, among other issues, the report should address the level of assistance required by the individuals who elect to use this benefit, as well as provide documentation of the types of services that are received. In addition, the report should include an analysis of the extent to which beneficiaries who receive in-home care are able to avoid or postpone permanent residence in a nursing home or other institutional setting.

The Committee bill would also require that the Secretary undertake a second, additional study relating to in-home care for the elderly who are chronically dependent. This report, to be made to the Congress not later than 18 months after the date of the legislation's enactment, is to contain information and recommendations regarding the provision of out-of-home services to chronically dependent individuals as an alternative to the in-home care to which these individuals are otherwise entitled. Such services include adult day care services (and other community-based arrangements) or nursing facility services. The purpose of this study is to learn more about the availability, accessibility, and appropriateness of providing these types of services as part of the in-home benefit package designed for chronically dependent individuals under this legislation. Thus, the Committee would expect this study to include information obtained from interviews with those Medicare beneficiaries who are receiving services under the in-home care benefit that this legislation would create. These interviews should establish the extent to which the limitation of services to the in-home setting has restricted the utilization and effectiveness of this benefit.

The new in-home care benefit would become effective on January 1, 1989.

Extending home health services (section 204)

Under current law, one of the requirements that must be satisfied in order for Medicare to cover home health care is that the care be required on an "intermittent" basis. This means, as a general rule, that persons who need care on a daily basis are not eligible for these services. The current guidelines for coverage, however, do permit daily skilled nursing visits for up to two or three weeks, if determined by the Medicare fiscal intermediary to be

medically necessary and reasonable. For this purpose, daily is defined as five days per week.

Concerns and criticisms have been raised about the implementation of this rule. The rule has not been uniformly and consistently applied. Moreover, it results in inadequate assistance for Medicare patients, particularly those who are discharged from hospitals in such a condition that they are unable to care for themselves or are in need of rehabilitative care.

The bill would expand and clarify the rule on intermittent care. Nursing care and home health aid services would be considered "intermittent", and reimbursable under Medicare, if they were furnished less than 7 days per week. In addition, these services could be provided 7 days per week for up to 35 days. They could be provided 7 days a week beyond 35 days if a physician certified that exceptional circumstances so required.

This provision would be effective on January 1, 1989.

Increase in maximum payment allowed for outpatient mental health services (section 205)

Under current law, the maximum amount that Medicare will reimburse for outpatient mental health treatments is $250 per year. Medicare will recognize only 62.5 percent of the reasonable charges for such services, and will pay only 80% of the recognized amount, with a total limit of $250 per year. As a consequence, the effective rate of coinsurance for an enrollee is 50% for the first $500 per year of treatments.

These limitations have not changed since the inception of the program in 1965 and are clearly inadequate to meet the needs of Medicare enrollees. These limitations encourage institutionalization of patients who need care but cannot afford to pay out-of-pocket for it and encourage undesirable billing and coding practices in order to maximize the availability of care.

The bill would increase the maximum amount of Medicare payments for such services to $1,000 in 1989. In order to avoid the erosion of the benefit over time, this limit would be increased in subsequent years by the Medicare Economic Index. (The MEI is the increase factor computed each year as the maximum increase in Medicare prevailing charges for physician services.) The current requirement of 50% cost-sharing would remain in effect, and only $250 in out-of-pocket expenses would be counted towards the catastrophic limit established under section 201 of the bill.

In addition, the bill would clarify that medical management physician visits are not considered to be treatments for purposes of this limitation. Medical management visits are visits of shorter duration than therapy or treatment sessions, and their main purpose is to permit the attending physician or psychiatrist to assess the patient's status, assess the treatment plan and the patient's progress, and perform necessary laboratory tests. Such visits are essential to the proper care of patients, but are discouraged under the current interpretation being followed by Medicare carriers, since any charges for such visits will decrease the availability of treatment. The Secretary has authority, under current law, to develop guidelines for the appropriate use and frequency of such visits, should he be concerned about potential abuses. Should the

Secretary seek to do so, the Committee would expect him to consult first with the physician and patient community on the need for and appropriateness of such guidelines.

The bill would not make any further changes, and the Committee intends none, with respect to other elements of current law regarding who can furnish such care or how the limit is applied.

Coverage of influenza vaccine and its administration (section 206)

Elderly Americans are far more susceptible than others to costly complications that may arise from influenza. As reported by the Office of Technology Assessment (OTA) to the Health Subcommittee at its 1982 hearings on the cost-effectiveness of the flu vaccine (Serial No. 97-128), during the period 1971-1978, 127,000 deaths and an estimated 16 percent increase in excess hospitalizations resulted from influenza, 80 to 90 percent of which occurred among those over age 65. More recent data from the Centers for Disease Control indicate that serious illnesses and deaths associated with influenza still remain a major health problem for the elderly.

OTA data also demonstrate that the cost to Medicare of such serious illnesses and hospitalizations could be avoided with adequate preventive measures, including widespread use of influenza vaccine. Again, during the years 1971-1978, these data show that flu shots not only increased the days of healthy life for persons age 65 and older, but also decreased the national level of their medical costs by $6.6 million. Such improvements and savings are particularly noteworthy, given the fact that they occurred with only a 22 percent flu vaccination rate among the elderly. Wider use of the vaccine by older Americans would undoubtedly result in even greater savings. In fact, the Congressional Budget Office (CBO) estimates that increasing the percentage of elderly who take influenza vaccine from 22 percent to 27 percent would yield Medicare savings of $15 million in 1988 alone.

For the last several years, the Department of Health and Human Services has acknowledged the cost-effectiveness of the flu vaccine through its recommendations to the general public that those at risk—including people 65 and older—be vaccinated against the disease each year. Yet, despite these recommendations, most of America's older population goes through the annual flu season without any vaccine protection.

Among the reasons cited at the Subcommittee's hearing for the elderly's low vaccination rate is the lack of coverage for flu shots under the Medicare program. In general, Medicare does not pay for preventive care services such as influenza vaccines. Thus, under current law, Medicare is authorized to pay for the treatment of influenza, but not for the vaccination that helps prevent this disease. Without such payment, seniors continue to be unwilling to take this simple preventive measure that could protect them against a catastrophic illness or even death.

The Committee bill would, therefore, amend the Medicare statute to provide coverage for the administration of vaccine against influenza. Under this provision of the bill, Medicare would pay 100 percent of the reasonable charge of the vaccination, without regard to the standard Medicare Part B deductible and coinsurance requirements. Beneficiaries would, therefore, have no out-of-pocket

expenditures if the physician takes assignment and accepts the Medicare reasonable charge as payment in full. If the physician does not accept assignment, the beneficiary would be responsible for the physician's charge in excess of Medicare's allowable level.

The costs of the vaccination would be financed entirely through an increase in the premium that is paid by all individuals enrolled in Part B of the Medicare program. It is anticipated that the amount of this increase would not exceed 20 cents per month. If, however, additional premium increases are needed in order for Medicare to pay for the vaccinations, the Committee bill would give the Secretary the authority to put such increases into effect.

The provision would be effective with respect to services furnished, and premiums paid, on or after January 1, 1989.

Mailing of notice of Medicare benefits and participating physician directories (section 207)

Surveys show that many Medicare enrollees do not fully understand what benefits are covered by Medicare or the limitations and constraints on those benefits. The Department of Health and Human Services currently publishes and distributes pamphlets describing the program, but misunderstandings remain. Of particular concern is the widespread misunderstanding that Medicare will cover nursing home and long-term care. Such misunderstandings may lead to enrollees making ill-informed decisions about purchasing supplemental policies or failing to take appropriate measures to secure needed health care. Passage of this bill would increase the need for enrollees to understand clearly the provisions of the Medicare program.

The Department recognizes the problem caused by enrollees' misunderstanding about Medicare's coverage of long-term care, as well as the need for an effective program of public education. The Secretary's report on catastrophic health care included a recommendation that such a program be undertaken. Members of the Committee have raised this issue with the Department on several occasions and have urged the Department to begin a public education program promptly.

The bill would require the Secretary to distribute a notice annually to all persons enrolled in either Part A or Part B, providing a clear and simple explanation of the benefits covered and those not covered under Medicare. In addition, the notice would explain the limitations on long-term care benefits under Medicare and Medicaid. It is the Committee's expectation that this would include, at minimum, an explanation inserted with the Social Security checks mailed to enrollees. It is also the Committee's intent that this be done within 90 days of enactment of the bill.

As part of the participating physician program created in 1984, the Department prepares directories of participating physicians, by area and specialty. These directories are currently made available in local Social Security offices, through hospitals, and through aging or consumer groups. In addition, enrollees are informed by a notice in their Social Security check envelopes that they can obtain a copy free from their Medicare carrier.

In order to provide greater access to these directories, the bill would require the Secretary to mail a copy to each enrollee.

Both provisions would be effective in 1988.

Requiring Medicaid buy-in of premiums and cost-sharing for poor Medicare beneficiaries (section 208)

Under current law, Medicare beneficiaries are obligated to meet certain deductible and coinsurance requirements under both Part A and Part B, as well as premium requirements under Part B. The Committee bill would restructure many of these cost-sharing requirements to establish catastrophic protection against hospital and physician expenses. However, all Medicare beneficiaries, regardless of income, would still be required to meet significant cost-sharing requirements before catastrophic protections are triggered.

In the case of those Medicare beneficiaries who are also eligible for Medicaid, most States, through their Medicaid programs, currently pay the Part B premiums under a "buy-in" agreement with the Medicare program. This assures that, for these individuals, Medicare pays the initial amounts of any claims for physician and other services covered under Part B, leaving the State Medicaid program with a supplementary role of paying for services that it covers, but which Medicare does not. States also pay Medicare deductibles and coinsurance on behalf of their dual eligibles. Federal Medicaid matching funds are available for such outlays, at the regular rate for services, with respect to Medicaid beneficiaries who are receiving cash assistance.

States also have the option, under their Medicaid programs, of paying Medicare cost-sharing requirements on behalf of low-income elderly and disabled Medicare beneficiaries who are not eligible for full Medicaid benefits. Under this option, added by section 9403 of P.L. 99–509, States may pay the Medicare cost-sharing for elderly and disabled individuals with incomes at or below a threshold established by the State that is no higher than 100 percent of the Federal poverty level. These individuals must also meet the resource standards of the Supplemental Security Income (SSI) program, although States that cover the "medically needy" may, at their option, apply their less restrictive "medically needy" resource in determining eligibility for this Medicaid "buy-in" coverage. If a State elects this option, it must, under current law, extend Medicare coverage to "some or all" of the optional categorically needy pregnant women and infants who are not eligible for Medicaid but whose incomes are below 100 percent of the Federal poverty level. Federal Medicaid matching funds are available, at the regular rate for services, with respect to the State expense of paying the Medicare cost-sharing for this optional categorically needy group, as well as for the costs of providing Medicaid benefits to pregnant women and infants.

According to the Congressional Budget Office, in 1986, about 3.3 million of the noninstitutionalized elderly 65 and over had incomes below the Federal poverty level. While virtually all of these have Medicare coverage, only about 1.1 million are covered under Medicaid. These dual eligibles may have their Medicare premiums, deductibles, and coinsurance obligations satisfied by the Medicaid program. The remaining two-thirds of the poor elderly must meet the Medicare cost-sharing requirements without help from Medic-

aid. Either they purchase "Medi-gap" insurance policies to pay the deductibles and coinsurance, or they pay the cost-sharing requirements directly out of pocket.

State Medicaid coverage of the elderly varies considerably. The following table, based on information supplied by the Congressional Research Service, sets forth, by State, the current Medicaid income eligibility levels for elderly persons living independently as a percentage of the Federal poverty level as of January, 1987. In most cases, these levels represent the maximum SSI benefit payment (the $340 Federal benefit plus any State supplement). In the 33 States which also cover the "medically needy," elderly individuals with higher monthly incomes may qualify for Medicaid by incurring high medical expenses which, when applied against their income, reduces their income to below the State's medically needy income level. (In all but 3 of these 33 States, the medically needy income level is lower than the maximum SSI benefit payment). The Committee observes that in only four States—Alaska, California, Connecticut, and Massachusetts—do Medicaid income eligibility levels for the elderly equal or exceed 100 percent of the Federal poverty level.

MEDICAID ELIGIBILITY LEVELS FOR ELDERLY INDIVIDUALS, BY STATE (JANUARY 1987)

	Monthly income level	Percent poverty ($458)
Alabama	$340	74
Alaska	632	[1] 110
Arizona	340	74
Arkansas	340	74
California	560	122
Colorado	398	87
Connecticut [2]	486	106
Delaware	340	74
District of Columbia	355	77
Florida	340	74
Georgia	340	74
Hawaii [2]	345	[1] 66
Idaho	413	90
Iowa	340	74
Illinois [2]	375	82
Indiana [2]	340	74
Kansas	340	74
Kentucky	340	74
Louisiana	340	74
Maine	340	74
Maryland	340	74
Massachusetts	469	102
Michigan	369	81
Minnesota [2]	375	82
Mississippi	340	74
Missouri [2]	340	74
Montana	340	74
Nebraska [2]	398	87
Nevada	376	82
New Hampshire [2]	367	80
New Jersey	371	81
New Mexico	340	74
New York	412	90
North Carolina [2]	340	74
North Dakota [2]	340	74

MEDICAID ELIGIBILITY LEVELS FOR ELDERLY INDIVIDUALS, BY STATE (JANUARY 1987)—Continued

	Monthly income level	Percent poverty ($458)
Ohio [2]	288	63
Oklahoma [2]	404	88
Oregon	342	75
Pennsylvania	372	81
Rhode Island	396	86
South Carolina	340	74
South Dakota	340	74
Tennessee	340	74
Texas	340	74
Utah [2]	350	76
Vermont	397	87
Virginia [2]	340	74
Washington	368	80
West Virginia	340	74
Wisconsin	442	96
Wyoming	340	74

[1] Federal poverty guideline for Alaska is $572 month, for Hawaii, $526 per month.

[2] States that do not automatically extend Medicaid coverage to aged or disabled persons receiving SSI benefits. Generally, individuals receiving SSI benefits are eligible for Medicaid in these States if they meet the State asset levels, which are lower than those under SSI. However, individuals with incomes higher than the levels indicated may qualify by "spending down," i.e., incurring medical expenses which, when applied against their incomes, reduce their incomes below the eligiblity levels.

The Committee bill proposes a number of Medicare benefit improvements designed to protect elderly and disabled Medicare beneficiaries against catastrophic financial expense. For Medicare beneficiaries with monthly incomes below $458 per month, however, these limited cost-sharing obligations will not be sufficient. Many of them will meet financial catastrophe long before they meet the $541 hospital deductible, the $1043 Part B cost-sharing "cap," and the $500 prescription drug deductible needed to trigger catastrophic protection under the bill. While States could protect this population through the Medicaid "buy-in" option under current law, it is the Committee's understanding that, to date, only one State has chosen to implement this coverage.

As a result of the proposed expansion of Medicare benefits to provide catastrophic coverage against hospital and physician costs, States, under their Medicaid programs, would realize significant savings. Dually eligible individuals who require extensive hospitalization and physician care would impose considerably less expense on State Medicaid programs than they do under current law, because payments that States now make for Medicare coinsurance and for services not currently covered by Medicare would no longer be necessary. In addition, some individuals who qualify for Medicaid by "spending down" to pay hospital and physician-related expenses not currently covered by Medicare would be protected from impoverishment by the bill's catastrophic benefits, and therefore remain ineligible for Medicaid. According to CBO, the aggregate Federal Medicaid savings resulting from the Medicare hospital and physician catastrophic limits in this bill would total an estimated $2.1 billion over the next five years. The state savings, in the aggregate, would total about $1.7 billion.

In the view of the Committee, this Medicaid "windfall" should be redirected toward catastrophic protection for the elderly and dis-

abled poor. Accordingly, the Committee bill would essentially make mandatory the Medicaid "buy in" option in current law. Effective July 1, 1988, the States would be required to pay the Medicare premiums, deductibles, and coinsurance for all elderly and disabled individuals with incomes at or below 100 percent of the Federal poverty level and resources at or below twice the SSI standard, or $3600. States would not be required to provide these individuals the full range of Medicaid benefits that they offer to categorically or medically needy beneficiaries; instead, they would be required only to pay Medicare cost-sharing on their behalf.

Under the bill, the income standard for this mandatory coverage group would be 100 percent of the Federal poverty income guidelines issued annually by the Department of Health and Human Services. These guidelines are based on poverty thresholds used by the Bureau of the Census to prepare its statistical estimates of the number of persons and families in poverty. For 1987, the income standard for an individual is $5,500 per year ($458 per month) for all States except Alaska and Hawaii. 52 *Fed. Reg.* 5340 (Feb. 20, 1987). Individuals with incomes above 100 percent of the poverty guidelines would not be eligible for this "buy-in", regardless of the amount of their incurred medical expenses; unlike "medically needy" coverage, "buy-in" coverage cannot be established by "spending down."

With respect to determining income eligibility for this "buy-in" coverage, the Committee intends that the States not use SSI standards or methodologies. In the case of married individuals, the Committee intends that the States, in determining income eligibility, not apply the poverty income guidelines for a family of two. Instead, the Committee expects that the states will attribute to each spouse one-half of all of the income, earned and unearned, received by either spouse, to each spouse, and apply that amount against the income guideline for a single individual. Thus, each member of a couple with a total annual income of $10,000 would be eligible for this coverage (assuming resource eligibility), since half of $10,000 meets the current poverty guideline for a single individual, even though their total income as a couple exceeds the poverty guideline of $7,400 per year for a family of two. In calculating income, the Committee expects that the States will either (a) multiply by four the individual's income for the three months preceding the determination of eligibility or (b) use the individual's actual income for the 12 months preceding the determination of eligibility. The States may require an applicant to furnish information that is reasonably necessary to substantiate his or her income.

With respect to determining resource eligibility for this "buy-in" coverage, the Committee expects that the State will use SSI methodologies for determining which assests are countable and which are not, and for valuing those resources. However, the State must use twice the SSI standards for countable resources; in 1987, this will result in a countable resource limit of $3,600 for an individual and $5,400 for a couple. As the SSI resource standard increases over time, the Medicaid "buy-in" resource standard will increase. The Committee notes that in 1974, when the SSI program was initiated, the resource standard was $1,500 for an individual. Had the 1974 standard been adjusted to account fully for inflation, the

standard in 1987 would be $3,400, not $1,800 as under current law. The Committee has set the resource standard at twice the SSI level for Medicaid buy-in purposes to assure those elderly with modest amounts of what the SSI program would consider "excess" resources are not denied protection against catastrophic health care costs.

The bill would require States to pay Medicare cost-sharing, including coninsurance, on behalf of eligible individuals. It is the understanding of the Committee that, with respect to dual Medicaid-Medicare eligibles, some States pay the coinsurance even if the amount that Medicare pays for the service is higher than the State Medicaid payment rate, while others do not. Under the Committee bill, States would not be required to pay the Medicare coinsurance in the case of a bill where the amount reimbursed by Medicare—i.e., 80 percent of the reasonable charge—exceeds the amount Medicaid would pay for the same item or service. However, if a State chooses to pay some or all of the coinsurance in this circumstance, Federal matching funds would, as under current law, be available for this cost. For example, assume that a physician actually charges a "buy-in" patient $60 for performing a particular procedure; that Medicare recognizes $50 as the reasonable charge; and that the State Medicaid program only pays $35 for this procedure. Whether or not the physician takes assigment, Medicare will pay only 80 percent of $50, leaving a $10 coinsurance obligation for the beneficiary. However, since the State only recognizes $35 as the fee for the procedure in question, and since the Medicare program has already paid the physician $40, the State is not required to pay any of the $10 coinsurance. If the State chooses to pay some or all of the $10, however, its cost would qualify for Federal matching payments at the regular rate for services.

The Committee bill would clarify that State expenditures for all Medicare cost-sharing expenses—premiums, deductibles, and coinsurance, under Part A or Part B—are eligible for Federal matching payments at the State's regular rate for service costs. This would apply whether the individual whose cost-sharing is being paid is eligible for Medicaid due to receipt of cash assistance, is eligible for Medicaid as a "medically needy" individual, or is eligible under the "buy-in" mandate of this bill as a "qualified Medicare beneficiary."

By making mandatory the current law "buy-in" option, the Committee bill would effectively require all States to provide Medicaid coverage to some or all pregnant women and infants who are not receiving cash assistance under the Aid to Families with Dependent Children (AFDC) program but who have incomes at or below 100 percent of the Federal poverty guidelines. It is the understanding of the Committee that at least 15 States have already elected to cover this optionally categorically needy group, and that most of these States have selected the 100 percent income threshold. The Committee bill would not require that all of the States cover all pregnant women and infants up to 100 percent of the poverty level; however, it would require that States cover these individuals below an income threshold set by the State that is higher than the State's current AFDC payment standard. As under current law, States covering these optional categorically needy pregnant women and infants must keep their AFDC payment levels at or above the

levels in effect on April 17, 1986. The effective date for coverage of some or all of these pregnant women and infants would be the same as for the "buy-in" mandate itself, July 1, 1988.

Adjustment in Medicare part b premium (section 209)

Persons enrolled in Part B of Medicare pay an monthly premium for such coverage. These premiums are established in advance for each calendar year. At present, the premium is calculated by the Secretary to be an amount sufficient, in the aggregate, to finance 25% of the estimated expenditures under Part B. Beginning with premiums for January 1989, however, the monthly premium cannot increase, under current law, by more than the percentage increase in Social Security cash benefits under the cost-of-living adjustment (COLA). The monthly premium is $17.90 in 1987, and is estimated by CBO to be $22.00 in 1988, $22.90 in 1989, $23.90 in 1990, $24.90 in 1991, and $26.00 in 1992.

Most of the revenue needed to finance the bill would be derived from the supplemental premium established under section 106. Additional premiums established under sections 202, 203 and 206. These revenues would not be adequate, however, to fully finance the program in each of the years. The bill, therefore, would increase the monthly premium by $1 in 1990 and by 40 cents in 1991. Because these increases would be incorporated into the premium and would be subject to the COLA increase, the net effect is that the monthly premium would be increased by $1.50 in 1991 and 1992.

The bill would also contain a provision making it clear that the transfer of payments for home health services from Part A to Part B, effectuated by section 105, will not have nay subsequent effect of increasing the monthly premium. The bill would require the Secretary, in calculating future premiums, not to take into account any increases in Part B expenditure due to this transfer.

Certain Medicare enrollees would not be paying the supplemental premiums established under section 106 of the bill. These would include residents of the U.S. Commonwealths of Puerto Rico and the Northern Mariana Islands and the Territories of Guam, the Virgin Islands, and American Samoa. It would also include persons who are enrolled in Part B of Medicare but who are not entitled to, and are not enrolled in, Part A. The latter group would not be paying the supplemental premium because they are not entitled to Part A. The residents of the commonwealths and territories would not be paying the supplemental premium because they are not subject to the Federal Internal Revenue Code and would not necessarily be filing a Federal income tax return.

The bill would provide that these persons will contribute to the financing of the additional catastrophic benefits of the bill by paying an additional monthly premium. In each case, the additional premium would be one-twelfth of the estimated annual per capita value of these additional benefits. For residents of the commonwealths and territories, the value would incude both Part A and Part B benefits, and would be adjusted by the ratio of the per capita value of Medicare benefits for such residents to the per capita value of Medicare benefits for residents of the U.S. For persons enrolled in Part B, but not Part A, the additional premium

would be based on the additional value of Part B benefits under the bill.

These additional premiums would become effective for residents of the commonwealths and territories in January 1988. For persons enrolled in Part B, but not Part A, they would become effective in January 1989.

Changes in certification of Medicare supplemental health insurance policies (section 210)

Section 1882 of the Social Security Act establishes requirements that insurance companies must meet in order to have their supplemental health insurance policies certified as "Medigap" policies. Section 1882 also includes criminal penalties for violating the provisions of that section, including penalties for knowingly selling a supplemental policy that substantially duplicates the benefits covered under Medicare. Insurance companies are also subject to State rules and regulations.

Medigap policies cover most of the current Part A and Part B cost-sharing, and sometimes include additional benefits. Over two-thirds of Medicare enrollees currently purchase such policies, at average annual premiums in excess of $500. The changes that would be made under this bill would clearly warrant significant changes in Medigap policies and in the requirements of section 1882. It is also clear that policy-holders need to be informed of these changes and their effect on current policies, and that companies issuing Medigap policies will need a reasonable period of time to adjust their policies to these changes and any corresponding changes made by the States.

The bill contains several provisions designed to bring Medigap policies into conformity with the changes made in Medicare. The Secretary of Health and Human Services would have to report to the Congress within 150 days of enactment of the bill, with recommendations for changes in the section 1882 requirements for certification. Before making such recommendations, the Secretary would have to take into consideration the changes in Medicare made by the bill and any recommendations made to him by the National Association of Insurance Commissioners.

The bill would also require insurers with Medigap policies in effect on January 1, 1988, to send a notice to all policyholders, by January 31, 1988, explaining the improved Medicare benefits enacted by the bill, and the effect of these improvements on the benefits and premium costs of the Medigap policy. Failure to do so would mean that the policy was no longer deemed to meet the requirements of section 1882. In addition, insurers would be required to submit their advertising to the State insurance commissioner (or comparable state officer) for review as to whether it complies with state law.

The criminal sanction for knowingly selling a policy that substantially duplicates Medicare benefits would be suspended from January 1, 1988 through December 31, 1988, with respect to policies issued prior to the enactment of the bill, if such policies would not have substantially duplicated Medicare benefits but for the enactment of the bill.

Extension of social HMO demonstration project (section 211)

Section 2355 of the Deficit Reduction Act of 1984 required the Secretary of Health and Human Services tc approve Medicare and Medicaid waivers needed to implement a demonstration project for social health maintenance organizations. These organizations are to provide an integrated package of health, long-term care, and social services on a prepaid, capitation basis for persons who voluntarily enroll with the organization.

There are currently four such demonstration projects, located in: Brooklyn, New York; Minneapolis, Minnesota; Portland, Oregon; and Long Beach, California. The project is currently scheduled to conclude in the Fall of 1988. However, the Committee believes that, if the project were to conclude at that time, it would not have been in effect for a sufficient period of time for valid conclusions to be drawn regarding the effectiveness of the program and the desirability of incorporating such a provision into the Medicare program.

The bill would direct the Secretary to extend the demonstration project, under the same terms and conditions as the current waiver, through September 30, 1992. An interim report on the project would be due to the Congress by December 1988, and a final report would be due by March 31, 1993.

Study of comprehensive medical coverage under the Medicare program (section 212).

The gaps and limitations in Medicare covered benefits have resulted in enrollees paying a higher and higher proportion of their incomes for health care services not covered by the program. Beneficiaries and consumer groups have indicated their desire that Medicare benefits be expanded. In order to assist the Congress in making better informed decisions on these issues, the General Accounting Office would be directed to assess the need for, and cost of, expanding Medicare benefits to include a range of additional benefits, including preventive care and screenings, vision care, dental services, hearing exams and services, comprehensive long-term care, and prescription drugs. The GAO would be directed to make separate determinations with respect to the costs of these services if they were to be furnished on a fee-for-service basis and under a capitation arrangement. The report to Congress would be due within six months after enactment.

Research on long-term care services for Medicare beneficiaries (section 213)

In order to assist the Congress in making policy decisions with respect to Federal support for long-term care services, the Secretary of Health and Human Services would be directed to conduct additional research on the delivery and financing of comprehensive long-term care for Medicare enrollees. The bill would authorize $5 million per year for each of five years, to be appropriated in equal parts from the Part A and Part B trust funds. Such funds and research are to be in addition to the level of research currently being conducted on such issues by all of the agencies and offices of the Department of Health and Human Services. The research would

encompass a range of issues with respect to access, quality, financing, and other aspects of long-term care.

Protection of income and resources of couple for maintenance of community spouse (section 214)

The leading cause of financial catastrophe among the elderly is the need for long-term care, especially the need for nursing home placement. The expense of nursing home care—which can range from $2,000 to $3,000 per month or more—has the potential for rapidly depleting the lifetime savings of all but the wealthiest. Even under the Committee's bill, Medicare's expanded skilled nursing facility benefits will not protect the elderly against the costs of long-term institutionalization. Private insurance coverage for nursing home costs is not generally available. For most of the elderly, the Medicaid program is the only third party source of payment for nursing home care.

Medicaid, a means-tested entitlement program, requires that the elderly or disabled nursing home resident be poor in order to qualify for coverage. It also limits the income that an institutionalized spouse may make available for the spouse remaining in the community. If the institutionalized spouse receives the pension and other income in his name, this limit may have the effect of impoverishing the spouse in the community. The purpose of the Committee bill is to end this pauperization by assuring that the community spouse has a sufficient—but not excessive—amount of income and resources available to her while her spouse is in a nursing home at Medicaid expense. This will be of particular benefit to older women, who, in the current generation at risk of nursing home care, have often worked at home all their lives raising families and have limited income other than their husbands' pension checks.

Current law.—To determine how much is available for the community spouse to live on when her elderly spouse in the nursing home applies for Medicaid, it is necessary first to determine whether the institutionalized spouse is eligible for Medicaid based on income and resources. If eligibility is established, it is then necessary to determine how much of the institutionalized spouse's monthly income is to be applied to the cost of nursing home care, and how much is to be available to the community spouse.

Eligibility standards.—In general, in order to qualify for Medicaid, an individual must be categorically related—that is, be aged, blind, disabled, or a member of a family with dependent children—and must meet certain income and resources standards.

In most States, elderly or disabled people receiving cash assistance under the Supplemental Security Income (SSI) program are automatically eligible for Medicaid. Aged or disabled individuals may receive SSI benefits if their countable income and countable resources do not exceed specified standards. The basic SSI income standard for an individual in 1987 is $340 per month, but many States have elected to supplement this benefit with their own funds. The basic SSI resource standard for an individual in 1987 is $1,800. In determining countable resources, a number of items are excluded, including the individual's home (of any value), household goods and personal effects worth less than $2,000, an automobile

with a market value of $4,500 or less, and up to $1,500 in life insurance or burial funds.

Not all States automatically extend Medicaid coverage to SSI beneficiaries. In about 14 States, known as "209(b)" States, eligibility standards, particularly resource rules, more restrictive than those under SSI are applied to the elderly or disabled. In about 35 States, elderly individuals who are not poor enough to qualify for SSI, but who have large, recurring medical expenses, such as nursing home bills, qualify for Medicaid as "medically needy." Finally, about 30 States offer coverage, on an "optional categorically needy" basis, to nursing home residents whose incomes fall below a State-established special income level no higher than 300 percent of the basic SSI benefit level ($1,020 per month in 1987).

There are roughly 1.5 million Medicaid beneficiaries in nursing homes, whether skilled nursing facilities (SNFs) or intermediate care facilities (ICFs). Less than one-fourth of those are poor enough to qualify for SSI cash assistance. The remaining three-fourths are eligible either as "medically needy" or "optional categorically needy." Individuals who qualify for Medicaid in nursing homes on either of these bases must apply a certain portion of their income toward the cost of their nursing home care. It is these post-eligibility rules, in combination with the rules for attributing income and resources, that give rise to the problem of "spousal impoverishment."

Attribution of income.—When one spouse enters a nursing home (or other institution) and applies for Medicaid, the following rule determines the amount of that spouse's income for eligibility purposes. Shortly after institutionalization, each spouse is treated as a separate household. Income—generally Social Security checks, pensions, and interest or dividends from investments—is considered to belong to the spouse whose name is on the instrument conveying the funds (in the case of Social Security checks, the amount attributed to each spouse is the individual's share of the couple's benefit). Thus, in a case where a couple's pension check is made out to the husband, if the husband enters a nursing home, all of the income is considered his for purposes of determining eligibility. If the wife in this case enters the nursing home, however, none of the income is considered hers, and the husband is under no obligation under Federal law to contribute any of his income toward the cost of her care. (However, some States do impose spousal contribution requirements in these circumstances).

Attribution of resources.—The rule for attributing resources is basically the same as that for attributing income. Of course, the only resources that are attributed are countable resources, commonly liquid assets like savings accounts, mutual fund investments, certificates of deposit, etc. Generally, in the month following institutionalization, resources to which a spouse has unrestricted access, including joint savings accounts, are considered available to that spouse for eligibility purposes. Thus, if resources are held solely by the institutionalized spouse, they are attributed to him for eligibility purposes. If the resources are jointly held, they are also considered to belong entirely to the institutionalized spouse, on the theory that he or she has an unrestricted right to use them. If the assets are held solely by the community spouse, however, they

are considered, after the first month, to belong to her. There is no obligation under Federal law on the part of the community spouse to contribute any amounts of resources toward the costs of care of the institutionalized spouse. In the view of the Department, these attribution rules apply in all States, including those with community property laws: this Departmental interpretation is currently the subject of litigation.

Transfer of resources.—States have the option of denying Medicaid eligibility to individuals who have transferred countable resources for less than fair market value within two years of applying for Medicaid. In the SSI program, the uncompensated value of the resource is counted for 24 months from the month the resource was disposed of, regardless of the amount at issue. States can be less restrictive than SSI, but they can also be more restrictive as well. Where the value of the resorces for which no compensation was received exceeds $12,000, the State may deny eligibility for more than 24 months, beginning with the date of the transfer. States may waive this penalty in cases where undue hardship would result. In the case of transfers of an individual's home to someone other than a spouse or minor or disabled child, the period for which eligibility is denied, if any, must be based on the relationship between the value of the home for which no compensation was received and the average Medicaid expenditure for nursing home care. States cannot deny eligibility if the individual intended to dispose of the home at fair market value or if denial would cause undue hardship.

Post-eligibility application of income.—Once an institutionalized spouse has established eligibility for Medicaid by meeting the applicable income and resource standards, some of his monthly income is reserved for his use and that of his spouse, and the rest is applied to the cost of nursing home care. These post-eligibility income rules apply whether the spouse qualifies for Medicaid as a "medically needy" or "optional categorically needy" individual. From the gross monthly income of the institutionalized spouse are deducted the following amounts, in the following order. First, there is reserved for the institutionalized spouse a personal needs allowance for clothing and other expenses of at least $25. Second, there is set aside an allowance for the maintenance needs of the community spouse. This amount, combined with the community spouse's income, if any, allows the community spouse a certain amount of income, or maintenance needs level. Third, if the institutionalized spouse has a family at home, an amount is set aside for the maintenance of the family. Finally, an amount is allowed for expenses incurred for medical care that is not covered by the State's Medicaid plan or by Medicare or other third party. Any income remaining after these deductions is used to reduce the amount that the Medicaid program pays to the nursing home for the care of the institutionalized spouse.

Under current regulations, the maintenance needs level for the community spouse may not exceed the highest of the SSI, State supplementation, or "medically needy" income standard in the State. As the following table, based on a March 1987, survey conducted by the American Association of Retired Persons, indicates, these community spouse maintenance needs levels vary greatly

from State to State. The maintenance needs level is the total of the amount of the community spouse's income and the amount set aside from the income of the institutionalized spouse. Thus, in a State with a maintenance needs level of $340, if the community spouse receives a monthly Social Security check of $150, the contribution from the institutionalized spouse is $190, not $340.

Community spouse maintenance needs levels

State:	*Maintenance needs level*
Alabama	$340
Alaska	632
Arizona	(1)
Arkansas	188
California	534
Colorado	229
Connecticut	375–450
Delaware	164
District of Columbia	362
Florida	340
Georgia	340
Hawaii	300
Idaho	Up to 393
Illinois	267
Indiana	340
Iowa	340
Kansas	341
Kentucky	192
Louisiana	187
Maine	350
Maryland	325
Massachusetts	354
Michigan	358–370
Minnesota	397
Mississippi	340
Missouri	340
Montana	340
Nebraska	375
Nevada	173
New Hampshire	354
New Jersey	372
New Mexico	340
New York	417
North Carolina	233
North Dakota	345
Ohio	258
Oklahoma	0
Oregon	342
Pennsylvania	373
Rhode Island	475
South Carolina	340
South Dakota	257
Tennessee	150
Texas	340
Utah	289
Vermont	398
Virginia	217–325
Washington	368
West Virginia	200
Wisconsin	442
Wyoming	195

[1] Arizona operates, under demonstration authority, a Medicaid program that does not cover nursing home or other long-term care benefits.

Court-ordered support. —In some cases, courts have issued orders against institutionalized spouses requiring them to make monthly support payments in certain amounts to their spouses in the community. The policy of the Health Care Financing Administration (HCFA) is that, notwithstanding such an order, the income of the institutionalized spouse is to be considered available to him for purposes of determining the amount of his contribution toward the cost of nursing home care. The only part of his income which HCFA policy acknowledges as available to the community spouse is the specified maintenance needs allowance. This interpretation is the subject of litigation.

Committee bill. —The improvement of individuals whose spouses reside in nursing homes and receive Medicaid benefits is not justifiable. The current maintenance needs levels for community spouses, which are limited by current Federal regulation, are inadequate. In some cases, they have forced community spouses, in desperation, to sue their husbands for support. The financial duress that these low maintenance needs levels impose on the community spouse may, in certain cases, even force the premature institutionalization of that spouse.

The Committee bill would end spousal impoverishment. It revises the current Federal requirements relating to attribution of income, attribution of resources, transfer of resources, and post-eligibility application of income. These revisions are limited to the context of a couple with one spouse in an institution who applies for or receives Medicaid. The purpose of these revisions is to assure that the community spouse in these circumstances has income and resources sufficient to live with independence and dignity.

This bill establishes a uniform national spousal protection policy that applies in all States, whether they are "SSI," "209(b)," "medically needy," or "special income level" States, and whether or not they are community property jurisdictions. Should Arizona at some point offer nursing home coverage through its Medicaid demonstration, these rules would apply to it as well.

The bill allows an institutionalized spouse to elect to be governed by the rules that were in effect in his State as of March 1, 1987, regarding the treatment of income, the protection of income for the community spouse, the transfer of resources to the community spouse. The purpose of this election is to assure that the bill does not inadvertently make a community spouse worse off than under current law with respect to protected income of with respect to the minimum protected resource level of $12,000. This election could be used by the institutionalized spouse either to increase the amount of income or resources available to the community spouse or to reduce it, thereby allowing the community spouse to qualify for Medicaid or other public assistance benefits herself. However, the bill does not permit either the institutionalized spouse or the community spouse to opt out of the rules regarding the treatment of countable resources at the time of initial eligibility determination, which impose, in effect, a maximum protected countable resource limit of $48,000 on the community spouse.

Eligibility standards.—The bill does not alter income or resource standards for Medicaid eligibility of the institutionalized spouse. Thus, if the current resource standard is $1,800, it would remain

$1,800 under this bill. Similarly, the bill generally does not alter current law as to what income or resources are countable, and which are not, or how income or resources are valued. The principal exception to this relates to the exemption for household goods and personal effects for the limited purpose of attributing resources at the time of institutionalization. The spousal protection rules in this bill apply regardless of whether the institutionalized spouse has qualified for Medicaid by meeting the eligibility standards as a categorically needy, optional categorically needy, or medically needy individual.

Attribution of income.—During any month that a spouse enters a nursing home, hospital, or other institution, the following attribution rules apply for purposes of determining eligibility. Income paid solely in the name of one spouse or the other is considered to belong to that respective spouse. Thus, no income paid solely to the community spouse is considered available to the institutionalized spouse for eligibility purposes. If the income is paid in the names of both spouses, half is considered available to the community spouse, and half to the institutionalized spouse. If income is paid in the name of either spouse and another person or persons, the income is considered available to each individual names in equal proportional shares, unless the instrument controlling the income specifically otherwise provides. The same principles apply in the case of income from trust property. In the case of income from a trust where there is no instrument establishing ownership, half of the income is attributed to the institutionalized spouse and half to the community spouse. These attribution rules are subject to rebuttal by the institutionalized spouse upon a showing, by preponderance of the evidence, that ownership interests are otherwise.

Attribution of resources.—The following rules would apply in determining the amount of countable resources at the time of application for Medicaid benefits by the institutionalized spouse. First, a determination would be made of the total value of all the countable resources held by either the institutionalized spouse, the community spouse, or both, on the day the institutionalized spouse began the continuous period of institutionalization during which he applies for Medicaid benefits. Any countable resources belonging to either or both spouses would be included in this determination, including resources from inheritance or previous marriages. For this purpose only, the current limit of $2,000 on the equity value of the exemption for household goods and personal effects would be inapplicable. Thus, all household goods and personal effects, regardless of value, would not be counted among the resources attributed to the couple or either spouse at the time of institutionalization for purposes of determining eligibility.

One half of the value of all these resources, known as the spousal share, would be attributed to each spouse. If the spousal share of the community spouse were less than $12,000, the institutionalized spouse would be allowed to transfer a sufficient amount to the community spouse to enable her to hold countable resources in her own name of a total of $12,000. The institutionalized spouse would not be required to make this transfer; however, any resources not solely in the ownership of the community spouse would be attributed to the institutionalized spouse and, to the extent they exceed-

ed the applicable resource standard (generally $1,800), would render the institutionalized spouse ineligible for Medicaid.

If the spousal share of the community spouse were greater than $48,000, the institutionalized spouse would have attributed to him, for purposes of determining eligibility, both his own spousal share and the resources attributed to the community spouse in excess of $48,000. This $48,000 limit represents four times the $12,000 protected resource level. In 1989 and each year thereafter, these dollar amounts would be increased by the percentage increase in the consumer price index for all urban consumers for each year since September 1987.

The attribution of resources into spousal shares, and the subsequent imposition of limits on the community spouse's shares, would occur only once, at the time of initial application. After the month in which an institutionalized spouse has met the resource eligibility standard and is determined to be eligible for benefits, no resources of the community spouse, regardless of value, would be considered available to the institutionalized spouse. Thus, if while the care of the institutionalized spouse is being paid for by Medicaid, the community spouse's countable resources grow to exceed the $48,000 initial limit, the State would not be authorized to require the community spouse to apply any excess toward the cost of care of the institutionalized spouse.

The Committee observes that, in many cases, the institutionalized spouse may not apply for Medicaid benefits until months after his admission to a nursing home. Often these individuals and their spouses have "spent down" a significant amount of their life savings to pay the nursing home charges. Repeated division of the couple's total resources into equal spousal shares at each application or reapplication for benefits would result in the pauperization of the community spouse, as the couple's total resources would effectively be reduced to twice the resource eligibility standard, generally $3600, before the institutionalized spouse qualified for Medicaid. Precisely the opposite result is intended by the Committee. For this reason, the bill requires, in effect, that a "snapshot" of the couple's total resources be taken at the time of initial institutionalization, and that attribution of resources into spousal shares proceed on the basis of that "snapshot," regardless of the point at which the institutionalized spouse actually files application for benefits. The Committee expects that the States, in reconstructing the couple's resources at the time of institutionalization, will not apply unreasonable documentation requirements.

Post-eligibility application of income.—After an institutionalized spouse has met the resource and income criteria for eligibility, the income attributed to that spouse would be applied as follows each month. (The rules relating to attribution of income for purposes of determination of eligibility, described above, would also apply for purposes of post-eligibility treatment of income). From the institutionalized spouse's income, the following amounts would be deducted, in the following order. First, at least $25 would be reserved for that spouse's personal needs. Second, a community spouse monthly income allowance would be set aside. Third, a family allowance would be deducted for each minor or dependent child, dependent parent, or dependent sibling of either spouse living with the com-

munity spouse. Finally, there would be deducted amounts for incurred expenses for medical care for the institutionalized spouse not paid for by Medicaid, Medicare, or another liable third party.

The community spouse monthly income allowance is the amount needed to bring the community spouse's monthly income, including any income otherwise available to her, up to a minimum level. This minimum level is defined as the sum of (1) an amount equal to 150 percent of the Federal poverty guidelines for a family of two, or $925 per month in 1987; (2) an excess shelter allowance (the amount by which mortgage expenses or rent, plus utility costs, exceed 30 percent of the amount in (1); and (3) one-half of the amount by which the income of the institutionalized spouse exceeds the sum of amounts (1) and (2). The community spouse's minimum monthly maintenance needs allowance may not exceed $1500 per month. In 1989 and each year thereafter, this amount would be increased by the percentage increase in the consumer price index for all urban consumers for each year since September 1987. This $1500 limit applies only to the amount that may be deducted from the institutionalized spouse's income for the maintenance of the community spouse; it does not in any way constrain the amount of income that the community spouse may receive in her own name from sources other than the institutionalized spouse.

The $1500 limit on the minimum monthly maintenance needs allowance is not absolute. Under the bill, the institutionalized spouse is entitled to an opportunity to demonstrate, at a fair hearing, that the minimum monthly maintenance needs allowance is inadequate to support the community spouse without financial duress. If the spouse makes this showing, by a preponderance of the evidence, the State would be required to establish an adequate monthly maintenance needs allowance in that case.

Under the bill, States would be required, upon request by either spouse or upon a determination of eligibility, to notify the institutionalized spouse of the amount of the community spouse monthly income allowance, the family allowance, the way in which the community spouse resource allowance was computed, and the spouse's right to a fair hearing. The bill makes clear that an institutionalized spouse who believes that the minimum monthly maintenance needs allowance for the community spouse is inadequate, or who believes that the State has not accurately determined the amount of monthly income actually available to the community spouse from other sources, is entitled to a fair hearing on either of these issues, as well as any other State determinations that adversely affect the income or resources available to the community spouse.

Court ordered support.—The Committee recognizes that there will be some instances in which the rules set forth in the bill do not take adequate account of the special circumstances affecting a particular community spouse. The bill therefore provides that, if a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance must be at least as great as the amount of the income ordered to be paid. Similarly, if a court has entered a support order against an institutionalized spouse requiring that spouse to transfer countable resources to the community spouse, the spouse may comply with the court's order

without running afoul of the transfer of assets prohibitions, even where the effect is to leave the community spouse with countable resources in excess of $48,000.

Transfer of resources.—The Committee is informed that a number of States have not made effective use of the authorities under current law to prevent affluent individuals from disposing of resources in order to qualify for Medicaid nursing home coverage. In the view of the Committee, Medicaid—an entitlement program for the poor—should not facilitate the transfer of accumulated wealth from nursing home patients to their non-dependent children. The Committee is also concerned by the arbitrary nature of current SSI policy relating to disposal of assets, under which the 2-year penalty for transfers is unrelated to the amount of the assets disposed of. Accordingly, the Committee bill replaces the current law option with a uniform national policy, mandatory on all the States, that is specific to Medicaid eligibility and that reasonably relates the value of the resources improperly transferred to the period of denial of eligibility.

Under the bill, States must determine whether each nursing home or hospital patient who applies for Medicaid has, within 2 years of application, disposed of any countable resources for less than fair market value. If such a transfer has occurred, the State must determine the value (as of the time of transfer) of the countable resources transferred for which the applicant received less than fair market value. The total uncompensated value of these countable resources must then be divided by the average cost, to a private patient at the time of application, of nursing home care in the State. This yields the number of months for which the individual is ineligible for Medicaid, beginning with the month in which the transfer took place. The Committee expects that, where practicable, the State should use the cost of nursing home care to private patients in the community in which the applicant is institutionalized.

To avoid inequitable results, the bill provides for a number of exceptions from the denial of eligibility for transfers of countable resources for less than fair market value.

First, the prohibition on transfer does not apply at all in the case of the transfer of an applicant's home to his or her spouse, child under 21, or blind or disabled adult child. The Committee recognizes that, so long as an individual lives in a home or intends to return to it, the home is not a countable resource. The purpose of this exception is to underscore that the transfer of an applicant's or beneficiary's home to the community spouse or to any minor or disabled children would be protected.

Second, the prohibition on transfers does not apply at all in the case of a transfer of countable resources to the community spouse of an institutionalized individual, or to another for the sole benefit of the community spouse. Since the Committee bill establishes rules for the attribution of resources of married couples at the time of institutionalization which reach both spouses, no purpose would be served by prohibiting transfers of countable resources from the institutionalized spouse to the community spouse.

Third, if an individual can demonstrate, to the satisfaction of the State, that he or she intended to dispose of the resources at fair

market value, or for other valuable consideration, denial of eligibility for Medicaid should not occur. The purpose of the Committee bill is to deter those who, through "gifting" or other disposal, knowingly seek to shelter assets from dissipation due to nursing home costs. The bill is not intended to penalize those who inadvertently, or through lack of sophistication, did not receive adequate compensation. Nor is the bill intended to deny eligibility to those who transfer resources to relatives or others by way of compensation for the informal care which these individuals have given to the applicant or beneficiary; the imposition of a penalty in such circumstances would have the unfortunate effect of discouraging family members and friends from caring for the frail elderly or disabled and helping them remain independent for as long as possible.

Finally, the Committee recognizes that there will be circumstances where, although an individual may have transferred assets in order to qualify for Medicaid benefits, the effect of denying Medicaid coverage for the specified period of time would be to seriously threaten the continuing care or well-being of the applicant or otherwise work an undue hardship. The Committee also recognizes that there will be circumstances where, with no expectation of needing nursing home care and no intent of qualifying for Medicaid, an individual may give away money or property, perhaps for a grandchild's education, and then later learn that, as a result of a rapid change in medical condition, such as a stroke, nursing home placement is suddenly required. The bill provides that where the State determines such circumstances exist, eligibility for Medicaid benefits must not be denied.

These prohibitions on transferring countable resources, and the exceptions to them, are mandatory on all the States. The Committee bill expressly provides that States are not authorized to impose more—or less—restrictive eligibility delays than those specified in the Committee bill. Thus, the States could not impose any penalties for transfers of resources on applicants or beneficiaries other than those in nursing homes or hospitals. Similarly, the current SSI policies relating to transfer of assets would no longer apply for purposes of determining Medicaid eligibility of applicants or beneficiaries in institutions or those outside.

Conforming changes.—Currently, a number of States that offer Medicaid coverage to the aged and disabled under the "medically needy" option use less restrictive income or resource methodologies in determining eligibility than apply to the aged and disabled under the SSI program. HCFA interprets current law to require that States use SSI income and resource methodologies under their medically needy programs for the elderly and disabled.

The current treatment of income and resources of institutionalized spouses—substantially revised by the Committee bill—is essentially the result of applying SSI principles in a Medicaid context. This is only one of many examples where principles that may be valid in the context of a cash assistance program are not appropriate in the context of a medical assistance program. The State Medicaid Directors Association has submitted a report to the Congress concluding that directly linking Medicaid and SSI income and resource methodologies results in impoverishment of the elderly and disabled, increased State and Federal costs, and burdensome ad-

ministrative practices. The Medicaid Directors offer a number of examples of SSI policies which are inappropriate when applied to Medicaid, such as the rule that resource eligibility is determined on the first day of the month. Following this SSI rule, if a nursing home patient has resources in excess of the allowable threshold ($1,800) on that day, he or she is ineligible for Medicaid throughout the rest of the month, even if the amount of excess resources is too small to enable the individual to pay for the entire month's nursing home costs.

In the view of the Committee, there is no justification for the rigid application of SSI eligibility rules to Medicaid medically needy programs. Prior to this HCFA interpretation, States had flexibility to establish income or resource methodologies less restrictive—i.e., more generous from the applicant's standpoint—than those under SSI. States should continue to have this flexibility. On the other hand, the Committee does not believe that the States should have the discretion to apply methodologies under their medically needy programs that are more restrictive—i.e., less generous from the applicant's standpoint—than those under SSI. The bill therefore provides that the State's methodology for determining eligibility for the medically needy aged and disabled shall be no more restrictive than that under the SSI program (or, in the case of families with children, under the corresponding Aid to Families with Dependent Children cash assistance program). To avoid any possible ambiguity, the bill provides that a methodology is considered to be "no more restrictive" if, using the methodology, individuals qualify for Medicaid even though they would not be eligible were the SSI methodology used, and individuals who would be eligible for Medicaid under the SSI methodology would not be ineligible under the State's medically needy methodology.

Effective dates.—The provisions relating to the treatment of income and resources for institutionalized spouses are effective for individuals residing in institutions on or after January 1, 1988. This includes spouses who were residing in nursing homes before that date, as well as spouses who are admitted on or after that date. The provisions relating to transfers of resources apply to all institutionalized individuals first applying for Medicaid on or after January 1, 1988, with respect to any transfers for less than fair market value occurring up to two years prior to the date of application. Both provisions are effective whether or not the Secretary of HHS has promulgated final implementing regulations. If the Secretary determines that a State requires State legislation, other than an appropriations bill, to implement these requirements, the provisions do not take effect until the first day of the first calendar quarter beginning after the close of the first regular State legislative session beginning after enactment. Finally, the provision allowing States to use less restrictive income and resource methodologies in their medically needy programs is October 1, 1982, the effective date of the current statutory language on which HCFA erroneously bases its current interpretation. No disallowances or other adverse actions may be taken against States based on the current statutory language relating to "same" methodologies.

Examples.—The following examples illustrate the operation of the Committee bill. Assume an elderly couple who together own a

home assessed at $110,000 and have a joint savings account, to which either spouse has unrestricted access, with a balance of $20,000. The husband's monthly income, from his Social Security benefit and his private pension, is $750. The wife, who worked at home all her life raising a family, has income of $150 from Social Security. The husband develops Alzheimer's disease and his wife, no longer able to care for him at home, must place him in a nursing home. The husband applies for Medicaid. The State covers "optional categorically needy" nursing home residents under a special income standard of $875 per month and a resource standard of $1,800. The State's maintenance needs allowance for community spouses is $340 per month.

Under current law, the husband is categorically related due to his age, and, as of the beginning of the first full calendar month after institutionalization, is eligible under the special income standard of $875. (Until the beginning of the first full calendar month, the wife's income is attributed to him, and he does not meet the special income standard). However, he must still meet the $1,800 resource standard. The entire amount in the couple's joint savings account is attributed to the husband, since he has unrestricted access to it, giving him excess resources of $18,200. Until he spends these excess resources, he will remain ineligible for Medicaid. If he gives the $18,200 to his wife, the State has the option of denying him Medicaid eligibility for more than 2 years from the date of transfer.

Assuming all the excess resources in the couple's joint account are applied to the cost of nursing home care, and assuming a private patient rate of $2,000 per month, it will take about 9 months for the husband to become resource-eligible for Medicaid. After eligibility has been established, the husband's income is applied as follows. First, an allowance of $25 is reserved for his personal needs. Then an allowance of $190 for the maintenance needs of his wife (the State standard of $340 minus the wife's own income of $150) is set aside. If the husband had no uncovered medical costs in the previous month, the remaining $535 of his income is applied to the cost of nursing home care. The remainder is paid by the State and Federal governments through Medicaid.

The wife in the community is left with the house, a monthly income of $340, and access to the $1,800 remaining in the couple's joint savings account. Before her husband entered the nursing home, the couple's total income ($900 per month) was about 146 percent of the Federal poverty level for a couple; after her husband's institutionalization, she has only $1,800 in liquid assets and her income places her at 75 percent of the Federal poverty level for a single individual.

In sharp contrast to current law, the Committee bill would not impoverish the wife in this case. At the time the husband enters the nursing home, only $750 in income would be attributed to him, and he would immediately be eligible under the State's special income standard. With respect to resources, half of the couple's total assets would be attributed to the wife and half to the husband. However, the bill allows the husband to transfer without penalty $12,000—the minimum community spouse resource allowance—to an account in his wife's name at any time. When the hus-

band has spent all but $1,800 of the remaining $8,000, he becomes resource-eligible for Medicaid. Assuming he applies all of these excess resources to the cost of his nursing home care at $2,000 per month, this will take about 4 months.

Once eligibility for Medicaid has been established, the husband's monthly income is applied as follows. First, $25 is set aside each month for a personal needs allowance. Second, $725 is reserved for the maintenance needs of the community spouse. The community spouse is allowed a minimum of $925, including her income; since the wife's income is only $150, she can receive at least $775 from the husband. However, since the husband's total income is less than $775, she receives only the total income less the $25 personal needs allowance, or $725. Nothing remains to reduce the cost of the husband's nursing home care to the Medicaid program.

Under the Committee bill, the wife is left with a monthly income of $875 (her Social Security check of $150 plus the maintenance needs allowance of $725), or about 190 percent of the Federal poverty level for a single individual. She also has $12,000 in savings in her name. The husband would qualify for Medicaid about 5 months earlier than under current law. The total Federal and State Medicaid payment to the nursing home would go up by $535 per month (the difference between the husband's $190 community spouse monthly income allowance under current law and the $725 allowance under the bill).

Another example will illustrate the effect of the bill's provision for an equal division of the couple's resources. Assume that the couple's joint savings account at the time of institutionalization contains not $20,000, but $50,000. Under the bill, the husband would be allowed, without penalty, to transfer $25,000 of this amount to an account in the wife's name. Of the remaining half, $23,000 would have to be spent before the husband would become resource-eligible for Medicaid. Under current law, all but $48,200 in the joint account has to be spent before the husband becomes eligible for Medicaid. (Although a couple with $50,000 in savings is likely to have household goods and personal effects valued at more than $2,000, the bill provides that all these items are not to be considered resources for purposes of determining the community spouse resource allowance).

The effect of the bill's ceiling of $48,000 on the community spouse resource allowance may be demonstrated by assuming that the couple has not $20,000, but $100,000 in joint savings accounts and jointly held stocks and mutual funds at the time of the husband's institutionalization. The bill allows the husband to transfer half of the jointly held resources, or $50,000, to the wife in her own name, subject to the limit of $48,000. Thus, the couple would have to spend $50,200 (the husband's $50,000 share, plus $2,000 excess resources from the wife's share, less the resource eligibility standard of $1,800) before the husband could qualify for Medicaid. Again, any household goods or personal effects would not be taken into account in determining the amount of the community spouse's resource allowance.

The effect of the bill on financial planning (or the lack thereof) can be illustrated with the following example. Assume that this couple has a total of $50,000 in savings, and because it has done no

financial planning, all of these resources are held by the husband in his own name when he is admitted to the nursing home. Under current law, the husband cannot qualify for Medicaid until all but $1,800 of this amount is spent. Under the bill, however, the husband may transfer $25,000 to the wife in her own name without penalty.

If one assumes that this couple, learning of the husband's disease, anticipated the need for institutionalization and transferred all of the $50,000 joint savings to the wife more than two years prior to application for Medicaid, the result under the bill is the same as in the previous example. Regardless of ownership, the resources are attributed in equal shares to each spouse. Until the wife's resources are reduced to $25,000, the husband is not resource-eligible for Medicaid. Under current law, the husband, with no resources attributable to him, would immediately qualify for Medicaid, and the wife would be under no Federal law obligation to contribute toward the cost of his care.

Finally, the concept of the resource "snapshot" at institutionalization is illustrated by the following example. Assume, as above, that couple has countable resources of $50,000, jointly held, at the time of the husband's admission to the nursing home. The husband does not apply for Medicaid upon admission; instead, the couple begins to spend it resources to pay for the cost of his care. After a year, the couple has spent $24,000 from its joint resources, and the husband applies for Medicaid. The State would then look back to the date of the husband's institutionalization for purposes of attributing resources. Since the wife's spousal share was $25,000 then, if the husband transfers his interet in $25,000 of the remaining resources to his wife, he will immediately be resource-eligible for Medicaid, since the remaining $1,000 would meet the $1,800 resource standard.

Study of adult day care services (section 215)

The Committee bill would require the Secretary of Health and Human Services to conduct a survey and report to the Congress on adult day care services that are currently being provided throughout the United States. Such a report is to include information on (1) the scope of adult day care services and the extent of their availability around the country; (2) the characteristics of the various entities (such as community-based programs, hospitals, and nursing facilities) that provide these services; (3) licensure, certification, and other quality standards that are applicable to those entities providing such services; (4) the cost and financing of adult day care services; and (5) the characteristics of individuals who use the services (including on the individuals' level of disability and on the availability of similar in-home care services).

The purpose of this review is to evaluate programs and projects that have already been established, so that Congress can properly consider the advisability of Medicare coverage for adult day care services. Thus, it is not the intention of the Committee that the Secretary undertake a demonstration project or in any other matter initiate or fund new adult day care programs. The Secretary is to report only on the current availability of services and on

the state of the art of the provision and monitoring of quality of adult day health services.

In addition to the material collected from the national survey, the Secretary's report to the Congress is to include various recommendations concerning the establishment of an adult day care benefit under the Medicare program. Among the issue to be addressed are the appropriate population to be served, the type of services to be provided, the qualifications for Medicare provider certification, and the method for reimbursement. More specifically, the Secretary is to make recommendations on who needs and uses adult day care services and what kind of organizational arrangements and staffing patterns would best meet these service requirements.

The Committee bill would require that the Secretary make his report to the Congress not later than 1 year after the enactment of this legislation.

TITLE III—UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

The bill would establish a 15-member Congressional Commission to make recommendations regarding Federal programs for comprehensive health care, and would authorize appropriations of $1.5 million for this purpose.

The Commission would be comprised of six members of the House appointed by the Speaker, six members of the Senate appointed by the President Pro Tempore, and three members appointed by the President. No more than eight members could be from the same political party. The Commission would select a chairman and vice chairman from among its members.

The Commission would examine shortcomings in the current delivery and financing of health care that limit or prevent access to comprehensive health care by the elderly and disabled and by all other Americans.

Within six months of enactment, the Commission would submit a report to the Congress, with findings and recommendations for appropriate legislative initiatives regarding comprehensive long-term care for the elderly and disabled. Within one year of enactment, the Commission would issue a comparable report on comprehensive health care services for the elderly and disabled and for all Americans.

For this purpose, comprehensive health care services would include hospital and physician services, screening examinations and other preventive care services, long-term care services, mental health services, prescription drugs, eyeglasses, hearing aids, and dentures. Comprehensive long-term care would include custodial and noncustodial services, furnished in facilities, the home, or community-based settings.

In making it recommendations, the Commission would consider the amount of funds necessary to finance needed services and possible sources of such funds, raised in a manner consistent with principles of social insurance. It would also consider the most effective and efficient manner of administering such services.

The Committee expects the Commission to examine carefully the effects of the current 29-month waiting period which the disabled

must satisfy before they become eligible for Medicare. For many of the disabled, this waiting period prevents their receiving health care during the period of time when they are most in need of it. Many of them do not have private health insurance during this crucial period and are unable to obtain rehabilitative or restorative care, while their condition worsens and many of them die. The Commission should examine, and make recommendations on, reducing or eliminating the waiting period, including an assessment of the costs and effects of the waiting period on the disabled.

The Commission would be empowered to appoint and compensate staff, procure consultants, hold hearings, request studies from the GAO and cost estimates from CBO, request technical assistance or the detail of employees from other Federal agencies, request support from the General Services Administration, obtain information from any Federal agency, and accept gifts or donations of services or property. The Commission would expire 30 days after the submission of its last report.

Hearings

The Committee's Subcommittee on Health and the Environment held four days of hearings on H.R. 1711, H.R. 1760, H.R. 1761, H.R. 1762, H.R. 2470, and H.R. 2485, on May 21, 27 and 28, and June 2, 1987. Testimony was received from 39 witnesses, representing beneficiary and consumer groups, health care providers, and a variety of other organizations.

Committee Consideration

On June 9, 1987, the Subcommittee on Health and the Environment met in open session and ordered reported the bill H.R. 2470, as amended, by a vote of 9 to 1, a quorum being present. On June 16 and 17, 1987, the Committee met in open session and ordered reported the bill H.R. 2470, with amendments, by a recorded vote of 30 to 12, a quorum being present.

Committee Oversight Findings

Pursuant to clause 2(l)(3)(A) of rule XI of the Rules of the House of Representatives, no oversight findings or recommendations have been made by the Committee.

Committee on Government Operations

Pursuant to clause 2(l)(3)(D) of rule XI of the Rules of the House of Representatives, no oversight findings have been submitted to the Committee by the Committee on Government Operations.

Committee Cost Estimate

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the Committee believes that the bill will reduce the deficit by a total of $907 million over the fiscal years 1988, 1989, and 1990.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, June 29, 1987.

Hon. JOHN D. DINGELL,
Chairman, Committee on Energy and Commerce, House of Representatives, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the attached cost estimate for H.R. 2470 Amended, the Medicare Catastrophic Protection Act of 1987, as ordered reported on June 17, 1987, by the Committee on Energy and Commerce.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,
Sincerely,

ROBERT F. HALE
(For Edward M. Gramlich, Acting Director).

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE

1. Bill number: H.R. 2470 as amended by the Committee.
2. Bill title: The Medicare Catastrophic Protection Act of 1987.
3. Bill status: As amended and ordered reported by the Committee on Energy and Commerce on June 17, 1987.
4. Bill purpose: To amend title XVIII of the Social Security Act to provide protection against catastrophic medical expenses under the Medicare program, and for other purposes.
5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
DIRECT SPENDING/OFFSETTING RECEIPTS					
Sec. 101 Provisions					
Eliminating the limit on covered hospital days:					
Budget authority	−10.0	−30	−60	−90	−130
Outlays	180.0	300	345	380	420
Eliminating enrollees' copayments for hospital coinsurance and reserve days:					
Budget authority	−15.0	−50	−95	−150	−210
Outlays	295.0	485	560	615	680
Limiting payment of the hospital deductible to the first stay each year:					
Budget authority	−20.0	−60	−110	−160	−220
Outlays	395.0	530	550	595	655
Indexing the first-stay hospital deductible amount to the COLA:					
Budget authority	(1)	−5	−15	−35	−65
Outlays	10.0	75	175	290	410
Changing the calculation of the pt. A premium:					
Budget authority	15.0	25	25	25	25
Outlays	15.0	25	25	25	25
Effect on trust fund from change in pt. A premium:					
Budget authority	−16.0	−27	−30	−30	−35
Outlays	0	0	0	0	0

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Sec. 102 Provisions					
Changing the requirements for coinsurance on SNF stays, and covering up to 150 days a year:					
Budget authority	−10.0	−30	−55	−85	−120
Outlays	170.0	275	315	350	385
Eliminating the prior hospitalization requirement for coverage of SNF stays:					
Budget authority	(1)	−2	−5	−10	−15
Outlays	0	40	55	65	75
Sec. 103 Provisions					
Eliminating the 210 day limit on hospice benefits:					
Budget authority	(1)	(1)	(1)	(1)	(1)
Outlays	(1)	1	1	1	1
Sec. 104 Provisions					
Changing blood deductible requirements from 3 per spell to 3 a year:					
Budget authority	(1)	−1	−2	−5	−5
Outlays	5.0	8	10	10	11
Sec. 105 Provisions					
Transferring home health benefits to pt. B:					
Effect on pt. A:					
Budget authority	0	130	445	865	1,360
Outlays	0	−2,896	−4,440	−5,106	−5,867
Effect on pt. B:					
Budget authority	0	3,435	4,690	5,270	6,075
Outlays	0	2,896	4,440	5,106	5,867
Sec. 201 Provisions					
Capping pt. B copayments:					
Budget authority	0	2,445	3,760	4,480	5,330
Outlays	0	2,065	3,515	4,310	5,125
Counting costs of certain screening tests toward cap:					
Budget authority	0	35	50	55	70
Outlays	0	30	50	55	65
Sec. 202 Provisions					
Covering catastrophic expenses for prescription drugs:					
Budget authority	0	965	1,890	2,320	2,600
Outlays	0	965	1,890	2,320	2,600
Increasing pt. B premium to cover resulting outlay costs:					
Budget authority	−90.0	−1,085	−2,015	−2,450	−2,740
Outlays	−90.0	−1,085	−2,015	−2,450	−2,740
Additional costs of Medicaid buy-in requirement due to drug benefit:					
Budget authority	0	20	35	55	75
Outlays	0	20	35	55	75
Sec. 203 Provisions					
Providing in-home personal care:					
Budget authority	0	145	285	380	485
Outlays	0	120	270	360	460
Increasing pt. B premium to cover resulting outlay costs:					
Budget authority	0	−120	−270	−360	−460
Outlays	0	−120	−270	−360	−460
Sec. 204 Provisions					
Extending home health benefits to 35 consecutive days:					
Budget authority	0	180	255	285	330
Outlays	0	155	240	275	315

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Sec. 205 Provisions					
Increasing limit on payments for outpatient mental health services to $1,000 a year:					
Budget authority	0	100	200	270	350
Outlays	0	85	185	255	335
Indexing limit to MEI:					
Budget authority	0	0	15	25	30
Outlays	0	0	15	25	30
Clarifying classification of medical management services:					
Budget authority	0	70	105	130	155
Outlays	0	65	100	125	150
Sec. 206 Provisions					
Covering costs of influenza vaccine:					
Budget authority	0	45	70	75	80
Outlays	0	40	70	75	80
Increasing pt. B premium to cover resulting outlay costs:					
Budget authority	0	−40	−70	−75	−80
Outlays	0	−40	−70	−75	−80
Sec. 208 Provisions					
Requiring state Medicaid programs to buy-in all Medicare beneficiaries with incomes below the Federal poverty line:					
Budget authority	70.0	360	425	490	535
Outlays	70.0	360	425	490	535
Sec. 209 Provisions					
Adjusting pt. B premium:					
Budget authority	−5.0	−65	−375	−610	−690
Outlays	−5.0	−65	−375	−610	−690
Sec. 214 Provisions					
Protecting community spouses from impoverishment:					
Budget authority	180.0	310	330	350	375
Outlays	180.0	310	330	350	375
Restricting transfer of assets:					
Budget authority	−125.0	−135	−145	−155	−165
Outlays	−125.0	−135	−145	−155	−165
Medicaid Savings					
Effects of Medicare provisions on Federal Medicaid costs:					
Budget authority	−80.0	−370	−555	−660	−780
Outlays	−80.0	−370	−555	−660	−780
Total direct spending/offsetting receipts:					
Budget authority	−106.0	6,245	8,778	10,200	12,430
Outlays	1,025	4,140	5,735	6,725	7,895
AMOUNTS SUBJECT TO APPROPRIATIONS					
Sec. 201 Provisions					
Administrative costs to implement copayment cap: Outlays	30.0	30	20	20	20
Notice to physicians for enrollees above the cap: Outlays	0	1	1	1	1
Sec. 202 Provisions					
Administrative costs for drug benefit: Outlays	90.0	120	125	130	135
Sec. 207 Provisions					
Annual notice to enrollees of benefits under Medicare (half from HI; half from SMI): Outlays	4.0	4	4	4	4

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Mailing directories of participating physicians to all enrollees: Outlays	25.0	25	25	25	25
Sec. 213 Provisions					
Providing research funding on long-term care (half from HI; half from SMI): Outlays	5.0	5	5	5	5
Sec. 308 Provisions					
Authorization of appropriations for commission on comprehensive health care: Outlays	1.5	0	0	0	0
Total amounts subject to appropriations: Outlays	156.0	185	180	185	190
REVENUES					
Sec. 106 Provisions					
Imposing an income-related supplemental premium: [2] Revenues	1,421.0	5,018	5,888	6,641	7,550
Total:					
Budget authority	−106.0	6,245	8,778	10,200	12,430
Outlays	1,181.0	4,325	5,915	6,910	8,085
Revenues	1,421.0	5,018	5,888	6,641	7,550
Change in deficit	−241.0	−693	27	269	535

[1] Less than $0.5 million.
[2] Estimates are from the Joint Committee on Taxation.

Note.—Components may not sum to total due to rounding. The effects of this bill fall within function 570 and function 550.

Basis of estimate: Under current law, Part A of Medicare (Hospital Insurance) pays most of the costs for Medicare-covered services provided by hospitals, skilled nursing facilities (SNFs), home health agencies, and hospices. Enrollees share the costs of services through a variety of copayment requirements, most of which are related to the first-day hospital deductible amount (which was $520 in 1987). Part B of Medicare (Supplementary Medical Insurance) pays for services provided by physicians, independent laboratories, and hospital outpatient departments. Under current law, SMI enrollees are responsible for the first $75 of covered medical expenses, plus 20 percent of all reasonable charges above the deductible amount.

Title I of H.R. 2470 would change the HI copayment requirements, generally effective January 1, 1988, with the result that Medicare's reimbursement costs would increase. It would also change the way in which the HI premium is calculated, which would affect only those enrollees not already entitled to HI benefits through previous payroll tax contributions. Title II of H.R. 2470 would alter copayment requirements under Part B of Medicare by capping each enrollee's annual liability for copayments, first effective for calendar year 1989. It would also provide for expansion of mental health and home health benefits under Medicare, and for additional benefits under Medicaid.

This amendment to H.R. 2470 would not affect Title I. It would be a substitution for Title II. It would provide new benefits under both Medicare and Medicaid in addition to those contained in the original bill. It would also require higher increases in the SMI premium to finance the additional benefits.

Estimates of the costs to Medicare from the copayment provisions of this bill were derived by simulating the effects of proposed changes on a 1 percent random sample of Medicare enrollees (about 300,000 enrollee records). Medicare reimbursement and copayment costs for these enrollees in 1985 under current law were aged to 1988 through 1992, using CBO's baseline projections for enrollment and reimbursements, separately for each major service category. Total Medicare reimbursements under current law were compared to what reimbursements would be after implementation of the proposed provisions to obtain the estimated costs of the benefit expansion.

Under current law, Medicare reimbursements per enrollee are projected to increase by about 9.6 percent annually between 1987 and 1992. Under this amendment bill, reimbursements per enrollee would increase by an estimated 11.4 percent annually over the same period. About 70 percent of the additional Medicare benefit costs would be due to the assumption by Medicare of some enrollees' copayment liabilities for current services. The remaining 30 percent of estimated costs would be due to increases in Medicare-covered services, due partly to expanded coverage and partly to increased use of services by enrollees in response to reduced cost-sharing. The utilization responses assumed in the estimates were based on regression analyses of health care use by Medicare enrollees with and without supplementary insurance coverage for their Medicare copayment costs, using 1984 Health Insurance Survey data.

The revenue estimates for the income-related premiums were obtained from the Joint Committee on Taxation, and were based on simulations on a stratified random sample of current income tax returns, projected through 1992.

The specific provisions of the bill are explained in detail below. Unless otherwise indicated, the Title I provisions would take effect on January 1, 1988, and the Title II provisions would take effect on January 1, 1988.

Direct spending/offsetting receipts

Section 101 provisions

Section 101 of the bill contains five provisions, discussed in turn below. The estimates in this section take account of Medicare's additional reimbursements to hospitals to compensate for Medicare enrollees' bad debt—that is, the failure by some enrollees to pay the deductible and coinsurance amounts for which they are liable. Estimates by the Inspector General of the Department of Health and Human Services indicate that about 4 percent of enrollees' copayment liabilities for hospital stays are bad debt, which is eventually paid by Medicare.

Eliminating the limit on covered hospital days: Under current law, Medicare will cover up to 90 days during each spell of illness, plus an additional lifetime reserve of up to 60 days. In addition, there is a lifetime reserve of 190 days for inpatient psychiatric care. This bill would eliminate the limit on covered hospital days for general care, but would retain the lifetime limit for inpatient psychiatric care. Only a fraction of a percent of enrollees (fewer

than 0.1 percent) exhaust their hospital benefits for general inpatient care each year, but the costs such patients incur are substantial. Covering these days would cost Medicare $180 million in fiscal year 1988. This estimate is based on information provided by the Health Care Financing Administration, indicating that this provision would add about 0.5 percent to total inpatient costs of Medicare-covered inpatient stays.

Eliminating enrollees' copayments for hospital coinsurance and reserve days: Under current law, enrollees pay one-fourth of the first-day hospital deductible amount for days 61–90 in a given spell of illness (coinsurance days), and one-half of the deductible amount for any lifetime reserve days used. This bill would eliminate enrollees' liability for coinsurance and reserve days. About 0.5 percent of HI enrollees use coinsurance or reserve days each year, accounting for an estimated 23 million coinsurance day and 0.7 million reserve days in 1988. Eliminating these inpatient coinsurance costs would cost Medicare $295 million in fiscal year 1988.

Limiting payment of the hospital deductible to the first stay each calendar year: Under current law, enrollees are liable for a hospital deductible each time they are admitted to the hospital in a new spell of illness (which begins on the 61st day following discharge from a previous inpatient episode). In 1988, about 800,000 enrollees will pay more than one first-day deductible under current law, while no one would be liable for more than one deductible each year under this bill. In addition, the bill contains a hold-harmless provision that would protect enrollees who were readmitted after January 1, 1988, within a spell of illness that had begun prior to that date from paying another deductible for such admissions. These provisions would cost Medicare an estimated $395 million in fiscal year 1988.

Indexing the first-stay hospital deductible to the COLA: Under current law, the first-day deductible is tied to increases in the index used to update payment rates under the prospective payment system. Under this bill, the deductible would instead be tied to increases in the (third-quarter) consumer price index (the Social Security COLA). This would slow the rate of growth in the deductible, because the update factor is projected to increase by 35 percent from 1987 to 1992, while the COLA is projected to increase by only 23 percent over the same period. In 1988, the deductible would be $544 under current law, but would be $541 if indexed to the COLA instead. By 1992, the deductible would increase to $700 under current law, but would be only $641 if indexed to the COLA. The additional costs to Medicare of this provision (after implementing all of the inpatient copayment provisions discussed above, as well as the SNF copayment provision discussed above) would be an estimated $10 million in fiscal year 1988.

Changing the calculation of the Part A premium: Under current law, the premium charged to HI enrollees who are not entitled to benefits through previous payroll tax contributions is based on the first-day deductible amount. Under this bill, the method of determining the premium would be charged so that it would reflect the actuarial value of HI benefits. This would reduce the projected monthly premium amount for 1988 from $236 to $155, affecting

about 23,000 enrollees. The costs to Medicare from this provision in fiscal year 1988 would be about $15 million.

Section 102 provisions

Section 102 contains provisions relating to Medicare coverage of stays in skilled nursing facilities (SNFs). They would change coinsurance requirements, provide for coverage of up to 150 days a year, and eliminate the 3-day prior hospitalization requirement for covered SNF care.

Changing the requirements for coinsurance on SNF stays, and covering up to 150 days a year: The bill would alter the way in which enrollees' coinsurance liability for stays in skilled nursing facilities is determined, and would change Medicare's coverage limits from 100 days per spell to 150 days a year. Under current law, coinsurance amounts equal to one-eighth of the hospital deductible amount ($68 per day in 1988) are charged each day for days 21–100 in SNFs during each spell of illness. Under the bill, enrollees would pay coinsurance amounts equal to 20 percent of Medicare's national average reasonable cost for the first seven days of each SNF stay; enrollees' coinsurance costs would be $23.50 per day in 1988 for each of the first seven days of each SNF stay.

Fewer than 2 percent of Medicare enrollees have covered SNF stays, but these enrollees will use about 8.6 million SNF days during 1988. These provisions would increase Medicare costs by $170 million in fiscal year 1988. About 80 percent of the costs would be due to lower coinsurance amounts paid by enrollees, while the remaining 20 percent of costs would be due to additional covered SNF days resulting from the change in coverage limits to 150 days a year. The estimate assumes that those enrollees who would exhaust their SNF coverage under current law (about 7,500 in 1988) would use the full 150 days allowed under the bill.

Eliminating the prior hospitalization requirement for SNF stays: This bill would remove the requirement that a Medicare enrollee be hospitalized for at least three days prior to admission to a SNF to be eligible for Medicare coverage, effective January 1, 1989. As a result, the number of people receiving the SNF benefit would increase. Increased costs resulting from this provision are estimated at $40 million for fiscal year 1989, based on findings from a demonstration and study conducted by the Health Care Financing Administration.

Section 103 provisions

Section 103 of the bill would eliminate the current 210-day lifetime limit on the number of days enrollees who are terminally ill may receive hospice services. Nearly 98 percent of hospice beneficiaries die before the 210-day limit is reached, but tabulations by the Health Care Financing Administration indicate that those who survive for the full 210 days of their hospice benefit live another 50 days, on average. Because not all of these additional Medicare costs under the hospiced benefit would be offset by reduced costs for inpatient, SNF, or home health services, there would be a small costs due to this provision, equal to about $0.4 million in fiscal year 1988.

Section 104 provisions

Under current law, enrollees are required to replace or pay for the first 3 pints of blood used each spell of illness. Section 5 of the bill would require enrollees to replace or pay for the first 3 pints of blood used each year. Medicare costs would increase under this provision because enrollees would pay for an estimated 156,000 fewer pints of blood used in 1988 than they would under current law, costing Medicare about $50 per pint. The additional costs to Medicare in fiscal year 1988 would be about $5 million.

Section 105 provisions

This section of the bill would transfer the financing for home health benefits from the HI trust fund to the SMI trust fund for all Part B enrollees, effective January 1, 1989. Medicare beneficiaries who are not enrolled under Part B could continue to receive home health benefits under Part A. This would generate no net outlay costs, but it would alter budget authority totals under the two trust funds.

Section 201 provisions

Capping Part B copayments: Under Section 201 of the bill, each SMI enrollee's liability for copayments under the program would be capped at $1,043 in 1989. In subsequent years, the value of the copayment cap would increase at the same rate as the third-quarter Consumer Price Index (the Social Security COLA). Under CBO's baseline projections, the COLA would increase by about 4 percent annually over the five-year projection period, so that the SMI copayment cap would be $1,185 in 1992.

More than 8 percent of SMI enrollees would be affected by the copayment cap in 1989. As a result, SMI benefit costs would increase by $2.1 billion in fiscal year 1989. By 1992, more than 10 percent of enrollees would be affected by the copayment cap, at a cost to Medicare of $5.1 billion during that year.

Counting costs of certain screening tests toward cap: The costs of annual colorectal examinations for enrollees age 65 or more, and of triennial mammograms for enrollees age 55 or more, would count toward the copayment cap. This would effectively reduce the copayment cap for enrollees who obtained such tests. As a result of this provision, about 70,000 additional enrollees would exceed the copayment cap and a larger share of enrollees' copayment costs would be assumed by Medicare for all enrollees above the cap. The incremental costs of this provision would be an estimated $30 million in fiscal year 1989.

Section 202 provisions

Covering catastrophic expenses for prescription drugs: Under current law, Medicare generally pays only for immunosuppressive drugs in the first year following a covered transplant operation. This section of the bill would expand Part B coverage to include all reasonable costs for prescription drugs above a deductible amount, which would be set at $500 for calendar year 1989 and indexed to the medical care component of the consumer price index (CPI-M) thereafter. The deductible amount for the drug benefit would not

count toward the SMI copayment cap. About 17 percent of SMI enrollees would benefit from this provision in 1989, at an estimated benefit cost of $965 million for the fiscal year. Details on estimation of the benefit costs are discussed here. There would be additional administrative costs as well, discussed in the section on amounts subject to appropriations.

Because the proposal involves a deductible amount, it is necessary to estimate not only total spending by Medicare enrollees on prescription drugs, but also how that spending is distributed among enrollees and what proportion of enrollees who would exceed the deductible amount would actually file for reimbursement. Each of these components is explained below.

Total spending on drugs by Medicare enrollees: The CBO estimate of 1988 annual per capita prescription drug spending by Medicare enrollees of $250 was based on data from the Consumer Expenditure Survey (CES)—a 1984 survey of household spending from the Bureau of Labor Statistics. The CES shows that per person spending for prescription drugs in households headed by an elderly person was $137 in 1984. This figure was adjusted to reflect the age composition of households and direct purchases of drugs by third parties. This adjusted estimate of spending per elderly person was projected to average $268 in 1989 and $331 in 1992, based on published forecasts of drug expenditures from the Health Care Financing Administration.

Distribution of spending: CBO estimates that 5.5 million Medicare beneficiaries—16.9 percent—would exceed a deductible of $500 on prescription drugs in 1989. This estimate is based on data from the 1977 Current Medicare Survey (CMS), a survey of about 5,000 Medicare beneficiaries. (The 1984 CES household-level expenditure data cannot be used to provide an estimate of how expenditures vary by person.) In order to estimate the 1989 distribution of drug spending, the CMS data were increased proportionately to reflect a mean of $268.

Utilization and spending changes in response to the new benefit: The estimates assume that use of prescription drugs would rise only slightly under this proposal. The small magnitude of this assumed response is based on two factors: (1) the large deductible and (2) the fact that drug utilization is primarily determined by physicians. Under the proposal only about 17 percent of enrollees would receive Medicare drug benefits. We assume that this deductible level would inhibit the increased use that might occur if, instead, drugs were provided at a lower deductible to a larger proportion of enrollees. Much of the potential induced demand for drugs under insurance is already reflected in baseline spending, because outpatient drugs are prescribed during physician visits. Since Medicare enrollees are already well insured for physicians' services under Medicare, Medicaid, and medigap policies, the addition of the proposed drug coverage would be expected to have little effect on prescription drug use.

Because several studies have estimated that up to 4 percent of all drugs that are dispensed to the elderly are provided free, this estimate assumes that many of these drugs no longer would be provided free to enrollees once Medicare reimbursement was available. A

spending increase of 2 percent was included in the estimate to reflect payment for previously free prescriptions by Medicare.

Participation rate: The bill requires that enrollees and/or pharmacists initiate the request for reimbursement, once the deductible has been exceeded. Those who use more than one pharmacist or who shop at nonparticipating pharmacies would have to request that the pharmacists add their prescription costs and forward them to the government. For a variety of reasons, some enrollees will not make this request and some pharmacies will not report all drug expenditures. For example, persons who are covered by employer-based insurance or who exceed the deductible by small amounts would have little motivation to apply for reimbursement. Hence, we assume that only 85 percent of eligible costs will actually be reimbursed.

Reimbursement limits: The bill would reimburse drugs at the lower of three limits: the actual charge, the average wholesale cost plus a $4.50 dispensing fee, or 125 percent of the cost of the lowest available generic drug plus a $4.50 dispensing fee. The dispensing fee would be indexed to the CPI–M.

The effect of several of these limits on reimbursement is clear. The requirement for setting reimbursement at the lowest available generic drug price would reduce reimbursement. The effect of the generic limit was based on data from the Food and Drug Administration, discussions with representatives of the Pharmaceutical Manufacturers Association and a variety of other experts. Based on these data and discussions, it appears that approximately one-half of all drugs sold have a generic equivalent, average markup of drugs by pharmacies appears to be approximately 40 percent, and the market share represented by generic drugs is increasing at a rapid rate. Given these factors, we estimated savings from the generic limit of 10 percent per year.

Increasing the Part B premium to cover resulting outlay costs: This bill would require all of the expected increase in outlays for the drug benefit to be funded by an increase in the Part B premium. Currently, Part B premiums are based on incurred reimbursement costs per aged Medicare enrollees and pay only about 25 percent of those costs. Outlay estimates were obtained by adjusting incurred expenditures to allow for lags in payment, which are due to claims processing time and the delay in claim submissions. The monthly premium increase required by the drug benefit would be an estimated $0.30 in 1988, $3.60 in 1989, $5.60 in 1990, $6.30 in 1991, and $6.80 in 1992.

Additional costs of Medicaid buyin requirement due to drug benefit: Under a later provision of this amended bill, Medicaid programs would be required to pay SMI premiums and Medicare copayment costs for all poor Medicare enrollees who satisfy specified income and assets tests. This drug benefit would generate additional costs under the buyin requirement, which would equal an estimated $20 million in fiscal year 1989.

Section 203 provisions

Providing in-home personal services: Under current law, Medicare pays only for medical services under the home health benefit. This section of the bill would provide for coverge of up to 120 hours

each year for in-home personal services for chronically dependent enrollees who could not be left alone in their homes, at an estimated cost of $120 million in fiscal year 1989.

Increasing the Part B premium to cover resulting outlay costs: The SMI premium would be increased by an amount projected to cover all additional costs under this new in-home benefit. The required additional monthly premiums—for this benefit alone—would be an estimated $0.40 in 1989, and $0.80 in 1990.

Section 204 provisions

Currently, Medicare enrollees are entitled to receive two to three weeks of daily home health visits. This bill would increase the limit to 35 days, and would clarify current law by specifying that "daily care" means up to 7 days a week. The estimated cost of this provision, which would be effective January 1, 1989, is $155 million for fiscal year 1989. The estimate is based on Medicare administrative data on the distribution of home health visits under current law, and on projections of the increased utilization that would result from clarifying the definition of daily care and increasing the limit on consecutive days.

Section 205 provisions

Increasing limit on outpatient mental health services: Current law limits reimbursement for outpatient mental health services to $250 a year per enrollee. This bill would increase the limit to $1,000 a year, effective for calendar year 1989. The coinsurance rate on the additional benefits would remain at 50 percent, as under current law, and the additional copayments resulting from this provision would not count toward the SMI copayment cap described elsewhere in this bill. The estimated costs for this provision are $85 million in fiscal year 1989. The estimate is based on current use rates for the mental health benefit and projected increases in utilization due to the higher limit. The estimates of increased utilization were based on results of a demonstration study of a similar benefit expansion conducted by the Department of Health and Human Services.

Indexing limit to MEI: The additional costs of indexing the mental health limit to the Medicare Economic Index, so that the $1,000 limit on mental health reimbursements for 1989 would grow to an estimated $1,120 by 1992, would be an estimated $30 million by that year.

Clarifying classification of medical management services: Current law would be clarified so that visits with physicians for medical management services would not be classified as mental health services, and would therefore not be counted toward the reimbursement limit for outpatient mental health services. The costs of this provision would be an estimated $65 million in fiscal year 1989.

Section 206 provisions

Covering costs of influenza vaccine: Medicare coverage would be expanded to include 100 percent of the reasonable costs of administration of influenza vaccine. An estimated 8.5 million enrollees would benefit from this provision, at a cost of $40 million in fiscal year 1989.

Increasing the Part B premium to cover resulting outlay costs: The SMI premium would be increased by an amount projected to cover all additional outlay costs under this influenza vaccine benefit. The required additional monthly premium—for this benefit alone—would be an esimated $0.10 in 1989, and $0.20 in 1990.

Section 208 provisions

Currently, state Medicaid programs may choose whether or not to pay Medicare premium and copayment costs for all Medicare enrollees with incomes below the poverty level. This bill would require states to cover these costs, thereby affecting approximately 46 states that do not currently provide this Medicaid benefit to all poor Medicare enrollees, effective July 1, 1988.

This differs from a similar provision under the original Title II for several reasons. First, the definition of poverty that would be used under the amended bill would be current federal poverty guidelines (published by the Office of Management and Budget) rather than those published by the Census Bureau for the second previous calendar year. Second, the asset test used under the amended bill would be twice as large as that specified under the original bill. Finally, this section would retain the linkage between increases in coverage of the elderly and increases in coverage for infants and pregnant women contained in current law.

The estimated costs of this provision are $70 million in fiscal year 1988. The cost estimate is based on counts from the Current Population Survey of poor Medicare enrollees who do not receive Medicaid benefits, and on Medicaid program data showing the current cost of the proposed benefits per Medicare-eligible Medicaid beneficiary.

Section 209 provisions

This section provides for several adjustments to the current-law SMI premium. (The premiums discussed here would be distinct from the new outlay-based premiums intended to finance the new drug, in-home care, and influenza vaccine benefits. Further, those new benefits would not enter into the calculation of insurance values discussed below.)

For most SMI enrollees, the SMI premium would be increased by $1.00 a month in 1990, and by an additional $0.40 a month in 1991, on top of the automatic increases that would result under current law. (Under current law, beginning in 1989 SMI premium increases may not exceed the rate at which Social Security benefits are adjusted each year to offset cost-of-living increases, as measured by the change in the third-quarter Consumer Price Index. This is referred to as the COLA.)

Two groups are exempt from the ad hoc premium increases described above, however, and would be subject to a different set of provisions. For residents of Puerto Rico and the other territories, the current-law SMI premium would be increased in 1988 and 1989 by the insurance value of the new Medicare HI and SMI benefits provided under this bill. For U.S. residents who are enrolled in Part B but who are not eligible for Part A benefits, the current-law SMI premium would be increased in 1989 by the insurance value of the new Medicare SMI benefits provided under this bill. Beginning

in 1990 and for all subsequent years, the premiums paid would be indexed to the COLA.

The net effect of these premium provisions would be to generate additional premium receipts of $5 million in fiscal year 1988, growing to $685 million by fiscal year 1992.

Section 214 provisions

Protecting community spouses from impoverishment: In the case of a couple where one is in a nursing home, this provision is intended to protect the spouse remaining in the community from being impoverished by Medicaid's requirements for coverage of the nursing home stay. It would require that states increase both the assets and the income that the community spouse could retain. These provisions would be effective January 1, 1988. Estimated costs are $180 million in fiscal year 1988.

Restricting transfer of assets: For institutionalized patients applying for Medicaid benefits, the bill would require states to examine the previous 24-month period to determine whether the applicant had transferred assets to others that would otherwise have been available to pay for their nursing home care. If so, eligibility for Medicaid coverage would be delayed. Approximately 18 states currently do this, and all would be required to do so under the bill. Estimated savings would be $125 million in fiscal year 1988.

Federal Medicaid savings

About 9 percent of Medicare enrollees are dually eligible for Medicaid benefits. For these enrollees, Medicaid generally pays both their copayment liabilities under Medicare and their SMI premium costs. Consequently, Medicaid costs would be reduced by this bill because of lower copayment costs for Medicare enrollees, partially offset by increased Medicaid costs for the higher SMI premiums. In addition, there would be some additional savings to Medicaid in states with "medically needy" programs because the copayment limitations provided under this bill would reduce the number of Medicare enrollees who would qualify for Medicaid benefits under such programs. Savings are estimated to be $80 million in fiscal year 1988.

Amounts subject to appropriations

Section 201 provisions

Administrative costs to implement copayment cap: Neither Medicare carriers nor the Health Care Financing Administration currently collect information on the amounts of coinsurance paid by enrollees for Part B benefits. To implement the copayment cap propopsed in this bill, comprehensive information about both deductible and coinsurance amounts paid under Part B would have to be compiled across all Medicare carriers for each SMI enrollee. The estimates of start-up and ongoing administrative costs under this proposal are based on discussions with the Bureau of Program Operations in the Health Care Financing Administration.

Notice to physicians for enrollees above the cap: The bill would require carriers to notify physicians serving enrollees whose copayment costs had exceeded the SMI copayment cap, encouraging

them to accept assignment on all subsequent claims for enrollees. The costs of this provision are estimated at $1 million each year.

Section 202 provisions

Administrative costs for drug benefit: Administrative costs for the drug benefit would be composed of startup costs, fixed ongoing costs, and claims processing costs. These would total $90 million for fiscal year 1988, growing to $135 million by 1992.

The costs for 1988 are entirely startup costs, necessary to finance the costs of hiring and training personnel, development and installation of computer hardware and software, and activities necessary to enroll pharmacists. Fixed ongoing costs would be used to increase central and regional Health Care Financing Administration office staff, to establish and maintain a nationwide data base of drug costs for enrollees, and to undertake utilization control and quality monitoring activities. Costs for claims processing would vary based on the number of claims that were processed, and on whether the claims were electronically submitted or not. In 1989, the estimated processing cost per claim is $1.20, and the estimate assumes that 33 million claims (for 50 million prescriptions) would be processed.

Section 207 provisions

Annual notice of benefits: Under this provision, the Department of Health and Human Services would be required annually to mail each HI or SMI enrollee an explanation of Medicare benefits, beginning with calendar year 1988. The funds would be taken equally from the HI and the SMI trust funds. Estimated costs for this provision are $4 million annually, based on previous experience with such mailings by the Social Security Administration and by the Health Care Financing Administration.

Participating physicians directories: In addition, the Department would be required to mail annually a directory of participating physicians to each SMI enrollee, beginning calendar year 1988. The costs of this provision are estimated to be $25 million a year, again based on previous experience by the Social Security and the Health Care Financing administrations.

Section 213 provisions

Section 213 would authorize an appropriation of $5 million annually for each year from 1988 through 1992, to conduct research on long term care services for Medicare enrollees. The funds would be taken equally from the HI and the SMI trust funds.

Section 308 provisions

The bill would create a Bipartisan Congressional Commission to make recommendations to the Congress on improving access to comprehensive health care services. The Commission would be charged to deliver two reports within a year of its creation—one on long-term care for the aged and disabled, and one on comprehensive health care for all Americans. It would be disbanded following release of these two reports. The bill authorizes an appropriation of $1.5 million for the Commission.

Revenues

Section 106 provisions

This section would impose an income-related, tax-based supplementary premium on all people eligible for benefits under Part A of Medicare, excluding nonresidents, effective January 1, 1988. For individuals who were eligible for only part of the year, this supplementary premium would be pro-rated for the part of year during which they were Medicare-eligible. The supplementary premium rates would be indexed to the rate of growth in the subsidy value of Medicare benefits. The Joint Tax Committee estimates that revenues from this income-related premium would total $1.4 billion in fiscal year 1988.

6. Estimated costs to State and local governments: This bill would have an effect on state and local government budgets, because of the savings that would accrue to state Medicaid programs from the new Medicare benefits and because of the requirements that states expand Medicaid benefits. The net effect is shown below.

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Effects of State/local Medicaid costs	140	260	190	190	170

7. Estimate comparison: None.

8. Previous CBO estimates: On May 20, 1987, CBO provided an estimate for H.R. 2470, the Medicare Catastrophic Protection Act of 1987, as ordered reported by the Ways and Means Committee. H.R. 2470 was then referred to the Energy and Commerce Committee which has made a number of amendments. The major changes from the Ways and Means bill include covering catastrophic expenses for prescription drugs, providing in-home personal care, and covering the costs of influenza vaccines—together with increases in the Part B premium to cover the outlay costs of these activities. The Energy and Commerce Committee would also count the costs of certain screening tests toward the catastrophic cap in Part B. Finally, the Energy and Commerce Committee has added to Medicaid provisions to protect community spouses from impoverishment and to limit the transfer of assets in order to qualify for Medicaid benefits, and altered a third Medicaid provision requiring all states to pay the Medicare premium and copayment costs for Medicare enrollees with incomes below the poverty line.

Over the past several weeks, the CBO has made a number of estimates of proposals that would have Medicare insure some prescription drug spending by its enrollees. In response to comments from the Administration and others, our data bases and estimating procedures have been improved. In particular, the data on which we base the mean and distribution of current law prescription drug spending have been changed, with two implications—the current methods result in what we believe to be better estimates and earlier estimates have been changed to reflect these improvements.

9. Estimate prepared by: Sandra Christensen, Holly Harvey, Don Muse, and Jack Rodgers.

10. Estimate approved by: C.G. Nuckols, for James L. Blum, Assistant Director for Budget Analysis.

Inflationary Impact Statement

Pursuant to clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee makes the following statement with regard to the inflationary impact of the reported bill:

The Committee believes that the bill as reported will not have a significant effect on health care costs or the general economy. Medicare enrollees will receive greater protection against the financial risks of prolonged illnesses or catastrophic injuries, but will finance this protection out of increased premiums. The bill includes measures to control the costs of expanded benefits.

Agency Views

The Secretary of Health and Human Services,
Washington, DC, June 15, 1987.

Hon. John D. Dingell,
Chairman, Committee on Energy and Commerce, House of Representatives, Washington, DC.

Dear Mr. Chairman: When the President announced in his State of the Union message this year that he would transmit to the Congress legislation providing for acute care, catastrophic coverage under the Medicare program, a dialogue began which emphasizes the substantial consensus across the Nation for providing the elderly with this protection. Indeed, the debate thus far has centered largely—not on whether to provide this protection—but on how to accomplish this goal.

Unfortunately, we are most concerned that unanimity on the need for the legislation could be jeopardized by the content of the bills currently being debated by the Ways and Means and Energy and Commerce Committees. These bills contort the concept the President endorsed: to provide an acute care, catastrophic benefit under Medicare. Instead, it appears that the legislation has become a vehicle for modifications and add-ons to the basic Medicare program.

Enactment of legislation of the variety currently under consideration in the Congress will result in a cruel hoax on the intended beneficiaries. These program add-ons, combined with the lower out-of-pocket threshold, result in program cost increases that quickly outpace the bill's financing, greatly jeopardizing the stability of the program's design. The elderly will once again be faced with uncertainty as to the dependability of their coverage. This Administration will not tolerate that result.

Preliminary estimates by the Medicare actuary and Treasury indicate that even without the estimated $7–9 billion annual cost of a drug benefit, by 1993 the House bill's program costs will exceed revenues, with a shortfall of close to $10 billion likely by the year 2000. I know that every member of the Committee shares the Administration's concern that this coverage must be self-financing

and budget-neutral. Given current projections as to the future solvency of the Medicare trust funds, such a shortfall would threaten Medicare itself—a truly catastrophic event this Administration cannot allow.

This Administration has continually expressed its opposition to the financing mechanism contained within H.R. 2470, the Medicare Catastrophic Protection Act of 1987. We prefer the Administration's premium approach that avoids the serious problems created when the financing for an insurance program is tied to the tax code.

The bill which emerged from the Ways and Means Committee contained a number of disturbing add-ons to the concept of a catastrophic health care proposal.

When H.R. 2470 was approved by the Energy and Commerce Health Subcommittee, the list of expansions grew even longer, as the Subcommittee added: a costly, new drug benefit; a new, in-home care benefit for homemaker services; a further expansion of the Ways and Means expansion for mental health coverage; and others. The merits of these proposals to the Medicare program can be debated, but this is not the appropriate vehicle on which to place additional and worrisome costs that will eventually threaten the entire Medicare program.

We strongly oppose the addition of a new drug benefit to the Medicare program. Our actuaries have estimated that the Ways and Means approach to the drug benefit could cost *$7 billion* the first year alone, and the Energy and Commerce approach *$9 billion.* Even if either of these provisions were to be enacted, this benefit could not be administered through Medicare until January 1989, or perhaps 1990, at the earliest. We believe that the administrative problems would be immense. Much further analysis is required before the Administration could even recommend an appropriate strategy.

Inclusion in the legislation of several provisions alone could cause recommendation of a veto, namely the mandated Medicaid buy-in, which impinges on an area best left to the States, and the well-intentioned but ill-advised drug benefit, which—if it could be crafted—would run into billions of dollars in expenditures per year.

While we continue to stand enthusiastically behind our desire to enact a catastrophic health care program to ensure this Nation's elderly against devastating acute illnesses, that is not what the legislation currently before the Congress has become.

Should this legislation reach the President's desk in its current form, other senior advisers and I would be forced to recommend a veto. This is not a step we would take lightly, for we are committed to providing the elderly and disabled with this catastrophic protection.

I strongly urge that you reconsider the direction in which this legislation is headed and steer it back toward our original goal of providing catastrophic health care insurance for the elderly and disabled. We are advised by the Office of Management and Budget

that enactment of H.R. 2470 would not be in accord with the program of the President.

Sincerely,

OTIS R. BOWEN,
Secretary.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

NOTICE OF MEDICARE BENEFITS

SEC. 1804. (a) The Secretary shall distribute annually a notice containing—

(1) a clear, simple explanation of the benefits available under this title and health care services for which benefits are not available under this title, and

(2) a description of the limited benefits for long-term care services available under this title and generally available under State plans approved under title XIX.

Such notice shall be mailed annually to individuals entitled to benefits under part A or part B of this title.

(b) There are authorized to be appropriated in equal proportions from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund such sums as may be required to provide for the annual publication and distribution of the notice described in subsection (a).

* * * * * * *

PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

DESCRIPTION OF PROGRAM

SEC. 1811. The insurance program for which entitlement is established by section 226 and 226A provides basic protection against the costs of [hospital, related post-hospital] *inpatient hospital services, extended care services* home health services, and hospice care in accordance with this part for (1) individuals who are age 65 or over and are eligible for retirement benefits under title II of this Act (or would be eligible for such benefits if certain government employment were covered employment under such title) or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under

title II of this Act (or would have been so entitled to such benefits if certain government employment were covered employment under such title) or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

SCOPE OF BENEFITS

SEC. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d)(2) to him (subject to the provisions of this part) for—

[(1) inpatient hospital services for up to 150 days during any spell of illness minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);]

(1) inpatient hospital services;

(2) [(A) post-hospital] extended care services for up to [100 days during any spell of illness, and (B) to the extent provided in subsection (f), extended care services that are not post-hospital extended care services] *150 days during any calendar year;*

(3) *subject to subsection (f),* home health services; and

(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each [and one], a subsequent period of 30 days, *and a subsequent extension period* with respect to which the individual makes an election under subsection (d)(1).

(b) Payment under this part for services furnished an individual [during a spell of illness may not (subject to subsection (c))] *may not* be made for—

[(1) inpatient hospital services furnished to him during such spell after such services have been furnished to him for 150 days during such spell minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);]

[(2) post-hospital] *(1)* extended care services furnished to him [during such spell after such services have been furnished to him for 100 days during such spell] *during a calendar year after such services have been furnished to the individual for 150 days during that year;* or

[(3)] *(2)* inpatient psychiatric hospital services furnished to him after such services have been furnished to him for a total of 190 days during his lifetime.

[(c) If an individual is an inpatient of a psychiatric hospital on the first day of the first month for which he is entitled to benefits

under this part, the days on which he was an inpatient of such a hospital in the 150-day period immediately before such first day shall be included in determining the number of days limit under subsection (b)(1) insofar as such limit applies to (1) inpatient psychiatric hospital services, or (2) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness (but shall not be included in determining such number of days limit insofar as it applies to other inpatient hospital services or in determining the 190-day limit under subsection (b)(3)).]

(c)(1) If an individual is an inpatient of a psychiatric hospital on the first day of medicare entitlement (as defined in paragraph (4)(A)) payment may not be made under this part during the period described in paragraph (2) for inpatient mental health services (as defined in paragraph (4)(B)) in excess of the number of days specified in paragraph (3).

(2) The period described in this paragraph—

(A) begins on the first day of medicare entitlement, and

(B) ends at the end of the first period of 60 consecutive days thereafter on each of which the individual is not receiving inpatient mental health services.

(3) The number of days specified in this paragraph for an individual is 150 days less the number of days (during the 150-day period immediately before the first day of medicare entitlement) during which the individual was an inpatient of a psychiatric hospital.

(4) In this subsection:

(A) The term "first day of medicare entitlement" means, for an individual, the first day of the first month for which the individual is entitled to benefits under this part.

(B) The term "inpatient mental health services" means—

(i) inpatient psychiatric hospital services, and

(ii) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness.

(d)(1) Payment under this part may be made for hospice care provided with respect to an individual only during two periods of 90 days each [and one subsequent period of 30 days], *a subsequent period of 30 days, and a subsequent extension period* during the individual's lifetime and only, with respect to each such period, if the individual makes an election under this paragraph to receive hospice care under this part provided by, or under arrangements made by, a particular hospice program instead of certain other benefits under this title.

(2)(A) * * *

(B) After an individual makes such an election with respect to a 90- or 30-day period *or a subsequent extension period* the individual may revoke the election during the period in which case—

(i) * * *

* * * * * * *

(e) For purposes of subsections (b) and (c), inpatient hosptial services, inpatient psychiatric hospital services, and [post-hospital] extended care services shall be taken into account only if payment is or would be, except for this section or the failure to comply with

the request and certification requirements of or under section 1814(a), made with respect to such services under this part.

[(f)(1) The Secretary shall provide for coverage, under clause (B) of subsection (a)(2), of extended care services which are not post-hospital extended care services at such time and for so long as the Secretary determines, and under such terms and conditions (described in paragraph (2)) as the Secretary finds appropriate, that the inclusion of such services will not result in any increase in the total of payments made under this title and will not alter the acute care nature of the benefit described in subsection (a)(2).

[(2) The Secretary may provide—

[(A) for such limitations on the scope and extent of services described in subsection (a)(2)(B) and on the categories of individuals who may eligible to receive such services, and

[(B) notwithstanding sections 1814, 1861(v), and 1886, for such restrictions and alternatives on the amounts and methods of payment for services described in such subsection, as may be necessary to carry out paragraph (1).

[(g) For definition of "spell of illness", and for definitions of other terms used in this part, see section 1861.]

(f) Subsection (a)(3) shall only apply to home health services provided to an individual during a month in which the individual is not entitled to benefits under part B.

DEDUCTIBLES AND COINSURANCE

SEC. 1813. (a)(1) The amount payable for inpatient hospital services furnished an individual during [any spell of illness] *the first period of continuous hospitalization (as defined in subsection (b)(3)) that begins in a calendar year* shall be reduced by a deduction equal to the inpatient hospital deductible *for that calendar year* or, if less, the charges imposed with respect to such individual for such services, except that, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed. [Such amount shall be further reduced by a coinsurance amount equal to—

[(A) one-fourth of the inpatient hospital deductible for each day (before the 91st day) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 60 days during such spell; and

[(B) one-half of the inpatient hospital deductible for each day (before the day following the last day for which such individual is entitled under section 1812(a)(1) to have payment made on his behalf for inpatient hospital services during such spell of illness) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 90 days during such spell;

except that the reduction under this sentence for any day shall not exceed the charges imposed for that day with respect to such individual for such services (and for this purpose, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed.]

[(2) The amount payable to any provider of services under this part for services furnished an individual during any spell of illness shall be further reduced by a deduction equal to the cost of the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to him as part of such services during such spell of illness.]

(2)(A) The amount payable to any provider of services under this part for services furnished an individual shall be further reduced by a deduction equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during each calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

(B) The deductible under subparagraph (A) for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1833(b) to blood or blood cells furnished the individual in the year.

[(3) The amount payable for post-hospital extended care services furnished an individual during any spell of illness shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day (before the 101st day) on which he is furnished such services after such services have been furnished to him for 20 days during such spell.]

(3)(A) The amount payable for extended care services furnished an individual in any calendar year shall be reduced by the coinsurance amount (promulgated under subparagraph (C) for that year) for each day (before the 8th day) on which he is furnished such services during the year.

(B) Before September 1 of each year (beginning with 1987), the Secretary shall estimate the national average per diem reasonable cost recognized under this title for extended care services which will be furnished in the succeeding calendar year.

(C) The Secretary shall, in September of each year (beginning with 1987) promulgate the coinsurance amount which shall apply to extended care services furnished in the succeeding year. Such amount shall be equal to 20 percent of the national average per diem cost estimated under subparagraph (B) in that year. If the coinsurance amount determined under the preceding sentence is not a multiple of 50 cents, it shall be rounded to the nearest multiple of 50 cents (or, if it is a multiple of 25 cents but not a multiple of 50 cents, to the next higher multiple of 50 cents).

[(b)(1) The inpatient hospital deductible for 1987 shall be $520. The inpatient hospital deductible for any succeeding year shall be an amount equal to the inpatient hospital deductible for the pre-

ceding calendar year, changed by the applicable percentage increase (as defined in section 1886(b)(3)(B)) which is applied under section 1886(d)(3)(A) for discharges in the fiscal year that begins on October 1 of such preceding calendar year, and adjusted to reflect changes in real case mix (determined on the basis of the most recent case mix data available). Any amount determined under the preceding sentence which is not a multiple of $4 shall be rounded to the nearest multiple of $4 (or, if it is midway between two multiples of $4, to the next higher multiple of $4).

[(2) The Secretary shall promulgate the inpatient hospital deductible and all coinsurance amounts under this section between September 1 and September 15 of the year preceding the year to which they will apply.

[(3) The inpatient hospital deductible for a year shall apply to—

[(A) the deduction under the first sentence of subsection (a)(1) for the year in which the first day of inpatient hospital services occurs in a spell of illness, and

[(B) to the coinsurance amounts under subsection (a) for inpatient hospital services and post-hospital extended care services furnished in that year.]

(b)(1) The inpatient hospital deductible for 1987 shall be $520. The inpatient hospital deductible for any succeeding year shall be an amount equal to the inpatient hospital deductible for the preceding year increased by the applicable increase percentage determined under section 215(i) in the previous year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

(2) Not later than November 15 of each year (beginning with 1987), the Secretary shall promulgate the inpatient hospital deductible under this subsection for the succeeding year.

(3) In this section, the term "period of continuous hospitalization" means, with respect to an individual, the period beginning on the first day the individual is furnished inpatient hospital services and ends on the individual's date of discharge (as established by the Secretary for purposes of section 1886) from the hospital (or, in the case of a transfer, hospitals) involved.

CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

Requirement of Requests and Certifications

SEC. 1814. (a) Except as provided in subsections (d) and (g) and in section 1876, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

(1) * * *

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

(A) * * *

(B) in the case of [post-hospital] extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis[, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services];

* * * * * * *

(6) with respect to inpatient hospital services or [post-hospital] extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 1861(k)(4), including any finding made in the course of a sample or other review of admissions to the institution) pursuant to the system of utilization review that further inpatient hospital services or further [post-hospital] extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or skilled nursing facility, as the case may be, received notice of such finding; and

(7) in the case of hospice care provided an individual—

(A)(i) in the first 90-day period—

(I) the individual's attending physician (as defined in section 1861(dd)(3)(B)), and

(II) the medical director (or physician member of the interdisciplinary group described in section 1861(dd)(2)(B)) of the hospice program providing (or arranging for) the care,

each certify, not later than two days after hospice care is initiated, that the individual is terminally ill (as defined in section 1861(dd)(3)(A)), [and]

(ii) in a subsequent 90- or 30-day period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill [;], *and*

(iii) in a subsequent extension period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill;

* * * * * * *

Payments for Emergency Hospital Services

(d)(1) * * *

* * * * * * *

(3) The amounts payable under the preceding paragraph with respect to services described therein shall, subject to the provisions of section 1813, be equal to [60] *100* percent of the hospital's reasonable charges for routine services furnished in the accommodations occupied by the individual or in semiprivate accommodations (as defined in section 1861(v)(4)), whichever is less, plus [80] *100* percent of the hospital's reasonable charges for ancillary services. If separate charges for routine and ancillary services are not made by the hospital, reimbursement may be based on [two-thirds of] the hospital's reasonable charges for the services received but not to exceed the charges which would have been made if the patient had occupied semiprivate accommodations. For purposes of the preceding provisions of this paragraph, the term "routine services" shall mean the regular room, dietary, and nursing services, minor medical and surgical supplies and the use of equipment and facilities for which a separate charge is not customarily made; the term "ancillary services" shall mean those special services for which charges are customarily made in addition to routine services.

* * * * * * *

HOSPITAL INSURANCE BENEFITS FOR UNINSURED INDIVIDUALS NOT OTHERWISE ELIGIBLE

SEC. 1818. (a) * * *

* * * * * * *

[(d)(1) The monthly premium of each individual for each month in his coverage period before July 1974 shall be $33.

[(2) The Secretary shall, during the next to last calendar quarter of each year determine and promulgate the dollar amount (whether or not such dollar amount was applicable for premiums for any prior month) which shall be applicable for premiums for months occurring in the following calendar year. Such amount shall be equal to $33, multiplied by the ratio of (A) the inpatient hospital deductable for that following calendar year, as promulgated under section 1813(b)(2), to (B) such deductible promulgated for 1973. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1, or, if a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1.]

(d)(1) The Secretary shall, during September of each year (beginning with 1987), estimate the monthly actuarial rate for months in the succeeding year. Such actuarial rate shall be one-twelfth of the amount which the Secretary estimates (on an average, per capita basis) is equal to 100 percent of the benefits and administrative costs which will be payable from the Federal Hospital Insurance Trust Fund for services performed and related administrative costs incurred in the succeeding year with respect to individuals age 65 and over who will be entitled to benefits under this part during that entire year.

(2) The Secretary shall, during September of each year determine and promulgate the dollar amount which shall be applicable for premiums for months occurring in the following year. Such amount shall be equal to the monthly actuarial rate determined under paragraph (1) for that following year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

(3) Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium under this section, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for individuals 65 and older as provided in paragraph (1).

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PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * * * *

SCOPE OF BENEFITS

SEC. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services, except those described in subparagraphs (B) and (D) of paragraph (2); and

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

[(A) home health services;]

(A)(i) home health services, and (ii) subject to section 1839(h)(4), in-home care for a chronically dependent individual for up to 120 hours in any calendar year;

* * * * * * *

In the case of in-come care (described in paragraph (2)(A)(ii)) provided to a chronically dependent individual on any day, such care provided for 3 hours or less on the day shall be counted (for purposes of the limitation in such paragraph) as 3 hours of such care.

* * * * * * *

(b) For definitions of ["spell of illness",] "medical and other health services"[,] and other terms used in this part, see section 1861.

PAYMENT OF BENEFITS

SEC. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to items and services described in section 1861(s)(10)(A), the amounts paid shall be 100 percent of the reasonable charges for such items and services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i) on the basis of a fee schedule under subsection (h)(1), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on the basis of an assignment described in section 1842(b)(3)(B)(ii), under the procedure described in section 1870(f)(1), or for tests furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, or (ii) on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate, (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, (F) with respect to expenses incurred for services described in subsection (i)(3) under the conditions specified in such subsection, the amounts paid shall be the reasonable charge for such services, and (G) with respect to items and services (other than clinical diagnostic laboratory tests) furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion), the amounts paid shall be 100 percent of the reasonable charges for such items and services; [and] (H) with respect to services of a certified registered nurse anesthetist under section 1861(s)(11), the amounts paid shall be 80 percent of the lesser of the actual charge or the fee schedule for such services established by the Secretary in accordance with subsection (l), *and (I) with respect to expenses incurred for covered outpatient drugs, the amounts paid shall be the amounts determined under subsection (m)(2),*

(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs *(A)(ii),* (D),

(E), and (F) of such section and unless otherwise specified in section 1881)—

* * * * * * *

(3) in the case of services described in subparagraphs [(D)] *(A)(ii), (D),* and (E) of section 1832(a)(2), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A) and for items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2), or a third opinion, if the second opinion was in disagreement with the first opinion) exceed 80 percent of such costs; and

(4) in the case of facility services described in section 1832(a)(2)(F), and outpatient hospital facility services furnished in connection with surgical procedures specified by the Secretary pursuant to section 1833(i)(1)(A), the applicable amount as determined under paragraph (2) or (3) of subsection (i).

Payment for in-home care for chronically dependent individuals shall be paid on the basis of an hour of such care provided.

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $75; except that (1) such total amount shall not include expenses incurred for items and services described in section 1861(s)(10)(A) *or for covered outpatient drugs,* (2) such deductible shall not apply with respect to home health services *or with respect to covered outpatient drugs,* (3) such deductible shall not apply with respect to clinical diagnostic laboratory tests for which payment is made under this part (A) under subsection (a)(1)(D)(i) or (a)(2)(D)(i) on the basis of an assignment described in section 1842(b)(3)(B)(ii), under the procedure described in section 1870(f)(1), or to a provider having an agreement under section 1866, or (B) on the basis of a negotiated rate determined under subsection (h)(6), and (4) such deductible shall not apply with respect to items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion). The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood

(or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

(c)*(1)* Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections [(a) and (b)] *(a), (b), and (f)* only whichever of the following amounts is the smaller:

[(1) $312.50] *(A) the amount specified in paragraph (2) for that year* or

[(2)] *(B)* 62½ percent of such expenses.

(2) The amount specified in this paragraph for 1989 is $1,250. The amount specified in this paragraph for each succeeding year is the amount specified in this paragraph for the preceding year increased by the percentage increase in the MEI (as defined in section 1842(b)(4)(E)(ii)) for the year involved. If any amount determined under the previous sentence is not a multiple of $10, it shall be rounded to the nearest multiple of $10.

(3) In this subsection, the term "treatment" shall not be construed as including medical management visits.

* * * * * * *

(f)(1) Notwithstanding subsections (a) and (b), if an individual has incurred out-of-pocket part B expenses (as defined in paragraph (2)) in a calendar year (beginning with 1989) in an amount equal to the part B catastrophic limit (established under paragraph (3)) for the year, payment under this part with respect to any additional incurred expenses in the calendar year shall be made as if—

(A) the deduction described in the second sentence of subsection (b) (relating to blood) no longer applied, and

(B) "100 percent" and "0 percent" were substituted for "80 percent" and "20 percent", respectively, each place either appears in subsection (a), in section 1833(i)(2), in section 1835(b)(2), and in subsections (b)(2) and (b)(3) of section 1881.

(2) In this subsection, the term "out-of-pocket part B "expenses" means—

(A) the deductions established under subsection (b), and

(B) the difference between the payment amount provided under this part and the payment amount that would be provided if "100 percent" and "0 percent" were substituted for "80 percent" and "20 percent", respectively, each place either appears in subsection (a), in section 1833(i)(2), in section 1835(b)(2), and in subsections (b)(2) and (b)(3) of section 1881.

Such term also includes reasonable expenses (as defined by the Secretary) incurred for an annual colorectal examination for cancer and reasonable expenses (as defined by the Secretary) incurred for a mammogram, once every third year, for detection of breast cancer.

(3)(A) The part B catastrophic limit for 1989 is $1,043. The part B catastrophic limit for any succeeding year shall be an amount equal to the part B catastrophic limit for the preceding year increased by the applicable increase percentage determined under section 215(i) in the previous year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

(B) Not later than November 15 of each year (beginning with 1988), the Secretary shall promulgate the part B catastrophic limit under this paragraph for the succeeding year.

(4) In applying paragraph (1) in the case of an organization receiving payment under clause (A) of subsection (a)(1) or under a reasonable cost reimbursement contract under section 1876—

(A) the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect, in the aggregate, the aggregate increase in payments that would otherwise be made with respect to enrollees in the organization if payments with respect to enrollees in the organization if payments were made other than under such clause or a contract or with respect to individuals furnished services through the facility if payments were to be made on an individual-by-individual basis, and

(B) the organization or facility shall provide assurances satisfactory to the Secretary that the organization or facility will not undertake to charge an individual during a year for services for which payment may be made under this part after the individual has incurred (whether through the organization, facility or otherwise) out-of-pocket part B expenses in the year in an amount equal to the part B catastrophic limit established under paragraph (3) for the year.

(5) In applying paragraphs (1) and (2), the amount specified in subsection (c)(2) is deemed to be $312.50.

(g) In the case of services described in the second sentence of section 1861(p), with respect to expenses incurred in any calendar year, no more than $500 shall be considered as incurred expenses for purposes of subsections [(a) and (b)] *(a), (b), and (f).* In the case of outpatient occupational therapy services which are described in the second sentence of section 1861(p) through the operation of section 1861(g), with respect to expenses incurred in any calendar year, no more than $500 shall be considered as incurred expenses for purposes of subsections [(a) and (b)] *(a), (b), and (f).*

(m)(1)(A) Before applying paragraph (2) with respect to expenses incurred by an individual for covered outpatient drugs dispensed in a calendar year, the individual must establish that the individual has incurred expenses for such drugs dispensed in the year (during a period in which the individual is entitled to benefits under this part) of the amount specified in subparagraph (C) for that year.

(B) If an individual applies to the Secretary to establish that the individual has met the requirement of subparagraph (A), the Secretary shall promptly notify the individual (and, if the application was submitted by or through a participating pharmacy, the pharmacy) as to whether or not the individual has met such requirement.

(C) The amount specified in this subparagraph for 1989 is $500. For each subsequent year, subject to subparagraph (D), the amount specified in this subparagraph is the amount specified in this subparagraph for the previous year increased by percentage change in the medical care component of the consumer price index for all urban consumers (U.S. city average, as published by the Bureau of Labor Statistics) during the 12-month period ending with August in that previous year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the next highest multiple of $1. In September of each year (beginning with 1989) the Secretary shall publish the deductible established under this subparagraph for the following year.

(D) If the monthly actuarial rate determined under section 1839(g)(1) for a year (after 1990) exceeds 120 percent of the monthly premium increase provided under section 1839(g)(2) for months in the preceding year, the Secretary shall increase the amount otherwise specified under subparagraph (C) for that year (and only for that year) by such an amount as will assure that—

(i) the aggregate amount of the monthly premium increase provided under section 1839(g) for the year for all enrollees,

is equal to—

(ii) the total of the benefits and administrative costs which the Secretary estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for covered outpatient drugs dispensed and related administrative costs incurred in such year for all such enrollees.

(2) Subject to the deductible established under paragraph (1)(A), the amount payable under this part with respect to a covered outpatient drug is equal to the actual charge for the drug, or, if lower, the applicable payment limit described in paragraph (3).

(3)(A) In the case of a covered outpatient drug that either is not a multiple source drug (as defined in paragraph (6)(A)) or is a multiple source drug and has a restrictive prescription (as defined in paragraph (6)(B)), the payment limit for the drug under this paragraph is the sum of—

(i) the product of (I) the number of tablets (or other dosage units) dispensed and (II) the average per tablet or unit wholesale price for the drug (as determined under paragraph (4)), and

(ii) an administrative allowance of $4.50.

(B) In the case of a covered outpatient drug that is a multiple source drug but does not have a restrictive prescription, the payment limit for the drug under this paragraph is the sum of—

(i) the product of (I) the number of tablets (or other dosage units) dispensed and (II) the amount specified under subparagraph (C), and

(ii) an administrative allowance of $4.50.

(C) The amount specified under this subparagraph with respect to a multiple source drug dispensed in a year is 50 percent of the highest of the average per tablet or unit wholesale price for any drug product described in paragraph (5)(A) with respect to that drug, as in effect as of January 1, 1987, increased, for each year after 1987 and up to the year involved, by the percentage increase in the consumer price index for all urban consumers (all items, U.S. city aver-

age, as published by the Bureau of Labor Statistics) for the 12-month period ending in August of the previous year.

(D) The Secretary, before each payment calculation period (as defined in paragraph (5)(C)), shall provide for the distribution to participating pharmacies (as defined in section 1842(i)) and to groups representing or assisting individuals entitled to benefits under this part, of information on the payment limits established under this paragraph.

(4)(A) For purposes of this subsection, the Secretary shall determine, with respect to dispensing of each covered outpatient drug in each payment calculation period, the average per tablet or unit wholesale price for the drug. Such average shall be based on the average wholesale price (or when available, the manufacturer's direct price) for purchases in reasonable quantities. Such determination shall be made for each payment calculation period based on whole or direct prices for the first day of the third month before the beginning of the period. The Secretary shall make such determination, and calculate the payment limits under paragraph (3) on a national basis; except that the Secretary may make such determination, and calculate such payment limits, on a regional basis to take account of limitations on the availability of drug products and variations among regions in the average wholesale or direct price for a drug product.

(B) In order to prevent abusive practices in the prescribing or dispensing of covered outpatient drugs, the Secretary may provide that payment for covered outpatient drugs many not be made they are prescribed or dispensed with excessive frequency or in excessive quantities.

(5) In this subsection:

(A) The term "multiple source drug" means, with respect to a payment calculation period, a covered outpatient drug for which there are 2 or more drug products which—

(i) are considered to be therapeutically equivalent (under the Food and Drug Administration's most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations", available on the first day of the third month before the beginning of the period), and

(ii) are sold or marketed during the period.

For purposes of clause (ii), a drug is considered to be sold or marketed during a period if it is listed in the publications referred to in clause (i) for the third month before the beginning of the period, unless the Secretary determines that such sale or marketing is not actually taking place.

(B) A drug has a "restrictive prescription" only if the prescription for the drug indicates, in the handwriting of the physician or other person prescribing the drug and with an appropriate phrase (such as "brand medically necessary") recognized by the Secretary, that the particular drug must be dispensed.

(C) The term "payment calulation period" means the 6-month period beginning with January of each year (after 1988) and the 6-month period beginning with July of each year (after 1988).

PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

SEC. 1835. (a) Except as provided in subsections (b), (c), and (e), payment for services described in section 1832(a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

(1) * * *

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations) that—

(A) * * *

* * * * * * *

(D) in the case of outpatient speech pathology services, (i) such services are or were required because the individual needed speech pathology services, (ii) a plan for furnishing such services has been established by a physician or by the speech pathologist providing such services and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician; [and]

(E) in the case of comprehensive outpatient rehabilitation facility services, (i) such services are or were required because the individual needed skilled rehabilitation services, (ii) a plan for furnishing such services has been established and is periodically reviewed by a physician, and (iii) such services are or were furnished while the individual is or was under the care of a physician[.]; *and*

(F) in the case of in-home care provided to a chronically dependent individual during a 12-month period, the individual was a chronically dependent individual during the 3-month period immediately preceding the beginning of the 12-month period.

* * * * * * *

AMOUNTS OF PREMIUMS

SEC. 1839. (a)(1) The Secretary shall, during September of 1983 and of each year thereafter, determine the monthly actuarial rate for enrollees age 65 and over which shall be applicable for the succeeding calendar year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to those enrollees age 65 and older will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees *(other than costs relating to covered outpatient drugs, costs relating to in-home care, as defined in section 1861(ff)(1), costs relating to influenza vaccine and its administration, and costs attributable to section 1812(f)).* In calculating the monthly actuarial rate, the Secretary shall include an appropriate amount for a contingency margin.

(2) The monthly premium of each individual enrolled under this part for each month after December 1983 shall, except as provided in subsections (b) [and (e)], *(e), (g), (h), and (i),* be the amount determined under paragraph (e).

(3) The Secretary shall, during September of 1983 and of each year thereafter, determine and promulgate the monthly premium applicable for individuals enrolled under this part for the succeeding calendar year. The monthly premium shall (except as otherwise provided in [subsection (e)] *subsections (e), (g), (h), and (i))* be equal to the smaller of—

(A) the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1) of this subsection, for that calendar year, or

(B) the monthly premium rate most recently promulgated by the Secretary under this paragraph, increased by a percentage determined as follows: The Secretary shall ascertain the primary insurance amount computed under section 215(a)(1), based upon average indexed monthly earnings of $900, that applied to individuals who became eligible for and entitled to old-age insurance benefits on November 1 of the year before the year of the promulgation. He shall increase the monthly premium rate by the same percentage by which that primary insurance amount is increased when, by reason of the law in effect at the time the promulgation is made, it is so computed to apply to those individuals for the following November 1.

Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for enrollees age 65 and older as provided in paragraph (1) and the deviation of the dollar amounts specified in this paragraph.

(4) The Secretary shall also, during September of 1983 and of each year thereafter, determine the monthly actuarial rate for disabled enrollees under age 65 which shall be applicable for the succeeding calendar year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to disabled enrollees under age 65 which will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees *(other than costs relating to covered outpatient drugs, costs relating to in-home care, as defined in section 1861(ff)(1), costs relating to influenza vaccine and its administration, and costs attributable to section 1812(f)).* In calculating the monthly actuarial rate under this paragraph, the Secretary shall include an appropriate amount for a contingency margin.

(b) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837), the monthly premium [determined under subsection (a) or (e)] *otherwise determined under this section (without regard to subsection (f))* shall be increased by 10 percent of the monthly premium so determined for

each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which he reenrolled, but there shall not be taken into account months during which the individual has attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1862(b)(3)(A)(iv) by reason of the individual's (or the individual's spouse's) current employment or months during which the individual has not attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a large group health plan as an active individual (as those terms are defined in section 1862(b)(4)(B)). Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have.

* * * * * * *

(e)(1) * * *

* * * * * * *

(3)(A) Notwithstanding the provisions of subsection (a), but subject to the provisions of subsections (g), (h), and (i) the monthly premium for each individual enrolled under this part for each month—

(i) in 1990 shall be $1.00 greater than the amount otherwise determined under subsection (a), and

(ii) in 1991 shall be 40 cents greater than the amount otherwise determined under subsection (a).

Any increases in premium amounts taking effect under this paragraph for months in a year shall be taken into account for purposes of determining increases in each subsequent year under subsection (a)(3).

(B) Subparagraph (A) does not apply to premiums determined under paragraph (4) or (5).

(4)(A) Notwithstanding the provisions of subsection (a), but subject to subsections (g), (h), and (i), in the case of an individual who is a resident of a commonwealth or territory during a month—

(i) in 1988 or 1989, the monthly premium otherwise determined for the individual under paragraph (1) or subsection (a)(3), respectively, shall be increased by the amount described in subparagraph (B) for that month; or

(ii) in a subsequent year, the monthly premium which shall apply shall be the amount described in subparagraph (C) for that month.

(B) The amount described in this subparagraph for a month in 1988 or 1989 for an individual residing in a particular commonwealth or territory is $\frac{1}{12}$th of the product of—

(i) the average, per capita additional benefits (and related administrative costs), as determined by the Secretary during September of the previous year, that will be payable under this title during the year by reason of the amendments made by the Medicare Catastrophic Protection Act of 1987 (other than sections 202, 203, and 206 thereof); and

(ii) the ratio (determined by the Secretary for that commonwealth or territory during September 1987) of—

(I) the per capita actuarial value of the benefits under this title for residents of the commonwealth or territory who are entitled to benefits under both part A and this part, to

(II) the per capita actuarial value of the benefits under this title for residents of the United States who are entitled to benefits under both part A and this part.

(C) The amount described in this subpargraph for a month in—

(i) 1990, is the sum of—

(I) the monthly premium established under subsection (a)(3) for months in 1989, and

(II) the amount described in subparagraph (B) for months in 1989,

increased by the premium percentage increase (as defined in subparagraph (E)(ii)) for 1990; or

(ii) a succeeding year is the amount described in this subparagraph for months in the previous year increased by the premium increase percentage for that succeeding year.

(D) If any amount determined under the previous provisions of this subparagraph is not a multiple of 10 cents, the Secretary shall round the amount to the nearest multiple of 10 cents.

(E) In this paragraph:

(i) The term "commonwealth or territory" means Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands.

(ii) The term "percentage premium increase", for a year, means the percentage determined under subsection (a)(3)(B) in the previous year.

(5)(A) Notwithstanding the provisions of subsection (a), but subject to subsections (g), (h), and (i), in the case of a part B only individual (as defined in subparagraph (E)) during a month—

(i) in 1989, the monthly premium otherwise determined for the individual under subsection (a)(3) shall be increased by the amount described in subparagraph (B); or

(ii) in a subsequent year, the monthly premium which shall apply shall be the amount described in subparagraph (C) for that month.

(B) The amount described in this subparagraph is $\frac{1}{12}$th of the average, per capita additional benefits (and related administrative costs) that the Secretary estimates (during September of 1988) will be payable under this part during 1989 by reason of the amendments made by the Medicare Catastrophic Protection Act of 1987 (other than sections 202, 203, and 206 thereof).

(C) The amount described in this subparagraph for a month—

(i) in 1990, is the sum of—

(I) the monthly premium established under subsection (a)(3) for months in 1989, and

(II) the amount described in subparagraph (B),

increased by the premium percentage increase (as defined in paragraph (4)(E)(ii)) for 1990; or

(ii) in a succeeding year is the amount described in this subparagraph for months in the previous year increased by the premium increase percentage (as so defined) for that succeeding year.

(D) If any amount determined under the previous provisions of this paragraph is not a multiple of 10 cents, the Secretary shall round the amount to the nearest multiple of 10 cents.

(E) In this paragraph the term "part B only individual" means, with respect to a premium for a month, an individual who—

(i) is not a resident of a commonwealth or territory (as defined in paragraph (4)(E)(i)) during the month,

(ii) is entitled to benefits under this part, and

(iii) is not entitled to (or, on application without payment of an additional premium, would not be entitled to) benefits under part A.

* * * * * * *

(g)(1)(A) The Secretary shall, during September of 1987 and of each year thereafter, determine a monthly actuarial rate for covered outpatient drugs which shall be applicable for the succeeding calendar year.

(B) Subject to subparagraph (C), such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to enrollees will equal 100 percent of the total of the benefits and administration costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for covered outpatient drugs dispensed and related administrative costs incurred in such calendar year with respect to such enrollees.

(C) In establishing the monthly actuarial rate under this paragraph for each year (after 1990), the Secretary shall take into account any net surplus or deficit of the aggregate amount of the monthly premium increases provided under paragraph (2) for previous years for all enrollees over the total of the benefits and administrative costs which the Secretary determines were paid from the Federal Supplementary Medical Insurance Trust Fund for covered outpatient drugs dispensed and related administrative costs incurred in such previous years for all such enrollees.

(2) Subject to paragraph (3), notwithstanding any other provisions of this section (except as provided in subsections (b) and (f)), the monthly premium of each individual enrolled under this part for each month in a year after December 1987 shall be increased by the monthly actuarial rate determined according to paragraph (1) for that year; except that if the increase determined under this paragraph is not a multiple of 10 cents, it shall be rounded to the nearest multiple of 10 cents.

(3) The increase in monthly premium under paragraph (2) for each month in—

(A) 1988 may not exceed $0.30,

(B) 1989 may not exceed $3.20,

(C) 1990 may not exceed $4.90, and

(D) a subsequent year may not exceed 120 percent of the monthly premium increase under paragraph (2) for months in the preceding year.

(h)(1)(A) The Secretary shall, during September of 1988 and of each year thereafter, determine a monthly actuarial rate for in-home care (as defined in section 1861(ff)(1)) which shall be applicable for the succeeding calendar year.

(B) Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to enrollees will equal 100 percent of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for in-home care provided and related administrative costs incurred in such calendar year with respect to such enrollees.

(C) In establishing the monthly actuarial rate under this paragraph for each year (after 1990), the Secretary shall take into account any net surplus or deficit of the aggregate amount of the monthly premium increases provided under paragraph (2) for previous years for all enrollees over the total of the benefits and administrative costs which the Secretary determies were paid from the Federal Supplementary Medical Insurance Trust Fund for in-home care provided and related administrative costs incurred in such previous years for all such enrollees.

(2) Subject to paragraph (3), notwithstanding any other provision of this section (expect as provided in subsections (b) and (f)), the monthly premium of each individual enrolled under this part for each month in a year after December 1988 shall be increased by the monthly actuarial rate determined according to paragraph (1) for that year; except that if the increase determined under this paragraph is not a multiple of 10 cents, it shall be rounded to the nearest multiple of 10 cents.

(3) The increase in monthly premium under paragraph (2) for each month in—

(A) 1989 may not exceed $0.40,

(B) 1990 may not exceed $0.70, and

(C) a subsequent year may not exceed 120 percent of the monthly premium increase provided under paragraph (2) for months in the preceding year.

(4) If the monthly actuarial rate determined under paragraph (1) for a year (after 1990) exceeds 120 percent of the monthly premium increase provided under paragraph (2) for months in the preceding year, the Secretary shall decrease the maximum number of hours of in-home care under section 1832(a)(2)(A)(ii) in that year (and only in that year) by such an amount as will assure that—

(A) the aggregate amount of the monthly premium increase provided under this subsection for the year for all enrollees,

is equal to—

(B) the total of the benefits and administrative costs which the Secretary estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for in-home care provided and related administrative costs incurred in such year for all such enrollees.

(i)(1) The Secretary shall, during September of 1988 and for each year thereafter, determine a monthly actuarial rate for influenza vaccine and its administration which shall be applicable for the succeeding calendar year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to enrollees will equal 100 percent of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for influenza vaccine and related administrative costs incurred in such calendar year with respect to such enrollees.

(2) Notwithstanding any other provision of this section (except as provided in subsections (b) and (f)), the monthly premium of each individual enrolled under this part for each month in a year after December 1988 shall be increased by the monthly actuarial rate determined according to paragraph (1) for that year; except that if the increase determined under this paragraph is not a multiple of 10 cents, it shall be rounded to the nearest multiple of 10 cents.

* * * * * * *

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) * * *

(b)(1) Contracts with carriers under subsection (a) may be entered into without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding.

(2) No such contract shall be entered into with any carrier unless the Secretary finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent. The Secretary shall publish in the Federal Register standards and criteria for the efficient and effective performance of contract obligations under this section, and opportunity shall be provided for public comment prior to implementation. *With respect to carrying out functions relating to payment for the Secretary may enter into contracts with carriers under this section to perform such functions on a regional basis.*

(3) Each such contract shall provide that the carrier—

(A) * * *

* * * * * * *

(G) will provide to each nonparticipating physician, at the beginning of each year, a list of the physician's maximum allowable actual charges (established under subsection (j)(1)(C)) for the year for the physicians' services mostly commonly furnished by that physician; [and]

(H) if it makes determinations or payments with respect to physicians' services, will implement—

(i) programs to recruit and retain physicians as participating physicians in the area served by the carrier, including educational and outreach activities and the use of professional relations personnel to handle billing and other problems relating to payment of claims of participating physicians; and

(ii) programs to familiarize beneficiaries with the participating physician program and to assist such beneficiaries in locating participating physicians;

(I) if it makes determinations or payments with respect to items and services furnished by a physician for which payment is made pursuant to section 1833(f) but not on an assignment-related basis, provide to the physician a notice that—

(i) states that the individual provided the service has reached the part B catastrophic limit on out-of-pocket expenses for the year, and

(ii) encourages the physician not to charge the individual amounts in excess of the reasonable charge recognized under this section and to accept payment on an assignment-related basis for physicians' services furnished the individual during the remainder of the year; and

(J) if it makes determinations or payments with respect to covered outpatient drugs, will—

(i) offer, at the option of participating pharmacies, to receive requests for payments for such drugs through electronic communications, and

(ii) respond to requests by paticipating pharmacies as to whether or not an individual has met the deductible requirement of section 1833(m)(1)(A) for a year;

* * * * * *

(c)(1) * * *

(2)(A) * * *

(B) In this paragraph:

(i) The term "clean claim" means a claim that has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this part.

(ii) The term "applicable number of calendar days" means—

(I) * * *

* * * * * * *

(III) with respect to claims received in the 12-month period beginning October 1, 1988, 25 calendar days (or 18 calendar days with respect to claims submitted by participating physicians *or by participating pharmacies*), and

(IV) with respect to claims received in the 12-month period beginning October 1, 1989, and claims received in any succeeding 12-month period, 24 calendar days (or 17 calendar days with respect to claims submitted by participating physicians *or by participating pharmacies*).

* * * * * * *

(h)(1) Any physician or supplier may voluntarily enter into an agreement with the Secretary to become a participating physician or supplier. For purposes of this section, the term "participating physician or supplier" means a physician or supplier (excluding any provider of services) who, before the beginning of any year beginning with 1984, enters into an agreement with the Secretary which provides that such physician or supplier will accept payment

under this part on an assignment-related basis for all items and services furnished to individuals enrolled under this part during such year *and, with respect to a supplier of covered outpatient drugs, is a participating pharmacy (as defined in subsection (i)(1))*. In the case of a newly licensed physician or a physician who begins a practice in a new area, or in the case of a new supplier who begins a new business, or in such similar cases as the Secretary may specify, such physician or supplier may enter into such an agreement after the beginning of a year, for items and services furnished during the remainder of the year.

* * * * * * *

(6) The Secretary shall provide that the directories shall be available for purchase by the public. The Secretary shall provide that each appropriate area directory is sent to each participating physician located in that area *and to each individual enrolled under this part and residing in that area* and that an appropriate number of copies of each such directory is sent to hospitals located in the area. Such copies shall be sent free of charge.

* * * * * * *

(i)(1) For purposes of this section, the term "participating pharmacy" means an entity which is authorized under a State law to dispense covered outpatient drugs and which has entered into an agreement with the Secretary, providing at least the following:

(A) The entity agrees—

(i) not to refuse to dispense covered outpatient drugs items stocked by the entity to any individual entitled to benefits under this part (in this section referred to as "medicare beneficiaries"), and

(ii) not to change medicare beneficiaries more for such drugs than the amount it charges to the general public.

(B) The entity agrees to keep patient records (including records on expenses incurred by medicare beneficiaries) for all covered outpatient drugs dispensed to all such beneficiaries.

(C) The entity agrees—

(i) to assist medicare beneficiaries in determining whether or not their expenses (for covered outpatient drugs dispensed in a year) have exceeded the deductible under section 1833(m)(1)(A), including providing the documentation necessary to establish this, and

(ii) on behalf and on the request of such a beneficiary, to submit to the carrier such documentation as the Secretary requires.

(D) The entity agrees, upon request of a medicare beneficiary, to provide a copy of the records maintained under subparagraph (B) to another participating pharmacy or to a carrier under this section.

(E) The entity agrees—

(i) to offer to counsel, or to offer to provide information to, each medicare beneficiary on the appropriate use of a drug to be dispensed and whether there are potential interactions between the drug and other drugs dispensed to the beneficiary; and

(ii) to advise the beneficiary on the availability (consistent with State laws respecting substitution of drugs) of therapeutically equivalent covered outpatient drugs.

(2) The Secretary shall provide to each participating pharmacy—

(A) a distinctive emblem (suitable for display to the public) indicating that the pharmacy is a participating pharmacy, and

(B) before the beginning of each payment calculation period, information on the payment limits established under paragraphs (3) and (4) of section 1833(m).

(3) The Secretary shall provide for periodic audits of participating pharmacies to assure that they do not impose charges in excess of the amounts permitted under paragraph (1)(A)(ii).

(4) Notwithstanding subsection (b)(3)(B), payment for covered outpatient drugs may be made on the basis of an assignment described in clause (ii) of that subsection only to a participating pharmacy.

* * * * * * *

STATE AGREEMENTS FOR COVERAGE OF ELIGIBLE INDIVIDUALS WHO ARE RECEIVING MONEY PAYMENTS UNDER PUBLIC ASSISTANCE PROGRAMS (OR ARE ELIGIBLE FOR MEDICAL ASSISTANCE)

SEC. 1843. (a) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981 *or after 1987,* enter into an agreement with such State pursuant to which all eligible individuals in either of the coverage groups described in subsection (b) (as specified in the agreement) will be enrolled under the program established by this part.

* * * * * * *

(g)(1) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981 *or after 1987,* enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the second sentence of subsection (b) shall not apply with respect to such agreement.

* * * * * * *

(h)(1) The Secretary shall, at the request of a State made before January 1, 1970, or during 1981 *or after 1987,* enter into a modification of an agreement entered into with such State pursuant to subsection (a) under which the coverage group described in subsection (b) and specified in such agreement is broadened to include individuals who are eligible to receive medical assistance under the plan of such State approved under title XIX.

* * * * * * *

APPROPRIATIONS TO COVER GOVRNMENT CONTRIBUTIONS AND CONTINGENCY RESERVE

SEC. 1844. (a) There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund—

(1) * * *

(2) such sums as the Secretary deems necessary to place the Trust Fund, at the end of any fiscal year occurring after June

30, 1967, in the same position in which it would have been at the end of such fiscal year if (A) a Government contribution representing the excess of the premiums deposited in the Trust Fund during the fiscal year ending June 30, 1967, over the Government contribution actually appropriated to the Trust Fund during such fiscal year had been appropriated to it on June 30, 1967, and (B) the Government contribution for premiums deposited in the Trust Fund after June 30, 1967, had been appropriated to it when such premiums were deposited.

In computing the amount of aggregate premiums and premiums per enrollee under paragraph (1), there shall not be taken into account premiums attributable to section 1839(g) such premiums shall be computed as though the clause "(other than costs attributable to section 1812(f))" was deleted from paragraphs (1) and (4) of section 1839(a).

* * * * * * *

PART C—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

[Spell of Illness

[(a) The term "spell of illness" with respect to any individual means a period of consecutive days—

[(1) beginning with the first day (not included in a previous spell of illness) (A) on which such individual is furnished inpatient hospital services or extended care services, and (B) which occurs in a month for which he is entitled to benefits under part A, and

[(2) ending with the close of the first period of 60 consecutive days thereafter on each of which he is neither an inpatient of a hospital nor an inpatient of a skilled nursing facility.]

* * * * * * *

Hospital

(e) The term "hospital" (except for purposes of sections 1814(d), 1814(f), and 1835(b), subsection (a)(2) of this section, *and* paragraph (7) of this subsection[, and subsection (i) of this section]) means an institution which—

(1) is primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

* * * * * * *

[For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection.] For purposes of sections 1814(d) and 1835(b) (including determination of whether an individual received inpatient hospital serv-

ices or diagnostic services for purposes of such sections), [section 1814(f)(2), and subsection (i) of this section] *and section 1814(f)(2),* such term includes any institution which (i) meets the requirements of paragraphs (5) and (7) of this subsection, (ii) is not primarily engaged in providing the services described in section 1861(j)(1)(A) and (iii) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r), to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. For purposes of section 1814(f)(1), such term includes an institution which (i) is a hospital for purposes of sections 1814(d), 1814(f)(2), and 1835(b) and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals. Notwithstanding the preceding provisions of this subsection, such term shall not[, except for purposes of subsection (a)(2),] include any institution which is primarily for the care and treatment of mental diseases unless it is a psychiatric hospital (as defined in subsection (f)). The term "hospital" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865. The term "hospital" also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsection, except that—

(A) * * *

* * * * * * *

[Post-Hospital Extended Care Services

[(i) The term "post-hospital extended care services" means extended care services furnished an individual after transfer from a hospital in which he was an inpatient for not less than 3 consecutive days before his discharge from the hospital in connection with such transfer. For purposes of the preceding sentence, items and services shall be deemed to have been furnished to an individual after transfer from a hospital, and he shall be deemed to have been an inpatient in the hospital immediately before transfer therefrom, if he is admitted to the skilled nursing facility (A) within 30 days after discharge from such hospital, or (B) within such time as it would be medically appropriate to begin an active course of treat-

ment, in the case of an individual whose condition is such that skilled nursing facility care would not be medically appropriate within 30 days after discharge from a hospital; and an individual shall be deemed not to have been discharged from a skilled nursing facility if, within 30 days after discharge therefrom, he is admitted to such facility or any other skilled nursing facility.]

Skilled Nursing Facility

(j) The term "skilled nursing facility" means (except for purposes of subsection (a)(2)) an institution (or a distinct part of an institution) which has in effect a transfer agreement (meeting the requirements of subsection (l)) with one or more hospitals having agreements in effect under section 1866 and which—

(1) is primarily engaged in providing to inpatients (A) skilled nursing care and related services for patients who require medical or nursing care, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;

* * * * * * *

except that such term shall not [(other than for purposes of subsection (a)(2))] include any institution which is primarily for the care and treatment of mental diseases. [For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection.] The term "skilled nursing facility" also includes an institution described in paragraph (1) of subsection (y), to the extent and subject to the limitations provided in such subsection. To the extent that paragraph (6) of this subsection may be deemed to require that any skilled nursing facility engage the services of a registered professional nurse for more than 40 hours a week, the Secretary is authorized to waive such requirement if he finds that—

(A) such facility is located in a rural area and the supply of skilled nursing facility services in such area is not sufficient to meet the needs of individuals residing therein,

(B) such facility has one full-time registered professional nurse who is regularly on duty at such facility 40 hours a week, and

(C) such facility (i) has only patients whose physicians have indicated (through physicians' orders or admission notes) that each such patient does not require the services of a registered nurse or a physician for a 48-hour period, or (ii) has made arrangements for a registered professional nurse or a physician to spend such time at such facility as may be indicated as necessary by the physician to provide necessary skilled nursing services on days when the regular full-time registered professional nurse is not on duty.

* * * * * * *

Home Health Services

(m) The term "home health services" means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnish-

ing such items and services to such individual) established and periodicially reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

(1) part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse;

(2) physical, occupational, or speech therapy;

(3) medical social services under the direction of a physician;

(4) to the extent permitted in regulations, part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary;

(5) medical supplies (other than drugs and biologicals) and durable medical equipment, while under such a plan;

(6) in the case of a home health agency which is affiliated or under common control with a hospital, medical services provided by an intern or resident-in-training of such hospital, under a teaching program of such hospital approved as provided in the last sentence of subsection (b); and

(7) any of the foregoing items and services which are provided on an outpatient basis, under arrangements made by the home health agency, at a hospital or skilled nursing facility, or at a rehabilitation center which meets such standards as may be prescribed in regulations, and—

(A) the furnishing of which involves the use of equipment of such a nature that the items and services cannot readily be made available to the individual in such place of residence, or

(B) which are furnished at such facility while he is there to receive any such item or service described in clause (A),

but not including transportation of the individual in connection with any such item or service;

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital. *For purposes of paragraphs (1) and (4) and sections 1814(a)(2)(C) and 1835(a)(2)(A), nursing care and home health aide services shall be considered to be provided or needed on an "intermittent" basis if they are provided or needed less than 7 days each week and, in the case they are provided or needed for 7 days each week, if they are provided or needed for an initial period of up to 35 consecutive days, and for a subsequent period based on a physician certification of exceptional circumstances requiring such services on such a basis.*

* * * * * * *

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) * * *

* * * * * * *

[(J) immunosuppressive drugs furnished, to an individual who receives an organ transplant for which payment is made

under this title, within 1 year after the date of the transplant procedure; and]

(J) covered outpatient drugs (as defined in subsection (t)(2)); and

* * * * * * *

(10)(A) pneumococcal vaccine and its administration *and influenza vaccine and its administration;* and

(B) hepatitis B vaccine and its administration, furnished to an individual who is at high or intermediate risk of contracting hepatitis B (as determined by the Secretary under regulations); and

* * * * * * *

Drugs and Biologicals

(t)*(1)* The term "drugs" and the term "biologicals", except for purposes of [subsection (m)(5)] *subsections (m)(5) and (s)(2)(J) and paragraph (2)* of this section, include only such drugs and biologicals, respectively, as are included (or approved for inclusion) in the United States Pharmacopoeia, the National Formulary, or the United States Homeopathic Pharmacopoeia, or in New Drugs or Accepted Dental Remedies (except for any drugs and biologicals unfavorably evaluated therein), or as are approved by the pharmacy and drug therapeutics committee (or equivalent committee) of the medical staff of the hospital furnishing such drugs and biologicals for use in such hospital.

(2) The term "covered outpatient drug" means—

(A) a drug which—

(i) is approved for safety and effectiveness as a prescription drug under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act, or

(ii) in the case of a drug which is biological product, is licensed under section 351 of the Public Health Service Act, and

(B) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act;

but does not include any drug or insulin provided to an inpatient as part of inpatient hospital services (described in subsection (b)(2)), as part of extended care services (described in subsection (h)(5)), or as an incident to physicians' services under subparagraph (A) or (B) of subsection (s)(2).

* * * * * * *

Reasonable Cost

(v)(1)(A) * * *

* * * * * * *

(G)(i) In any case in which a hospital provides inpatient services to an individual that would constitute [post-hospital] extended care services if provided by a skilled nursing facility and a quality control and peer review organization (or, in the absence of such a qualified organization, the Secretary or such agent as the Secretary

may designate) determines that inpatient hospital services for the individual are not medically necessary but [post-hospital] extended care services for the individual are medically necessary and such extended care services are not otherwise available to the individual (as determined in accordance with criteria established by the Secretary) at the time of such determination, payment for such services provided to the individual shall continue to be made under this title at the payment rate described in clause (ii) during the period in which—

(I) such [post-hospital] extended care services for the individual are medically necessary and not otherwise available to the individual (as so determined),

(II) inpatient hospital services for the individual are not medically necessary, and

(III) the individual is entitled to have payment made for [post-hospital] extended care services under this title,

except that if the Secretary determines that there is not an excess of hospital beds in such hospital and (subject to clause (iv)) there is not an excess of hospital beds in the area of such hospital, such payment shall be made (during such period) on the basis of the amount otherwise payable under part A with respect to inpatient hospital services.

* * * * * * *

(2)(A) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or [post-hospital] extended care services is in accommodations more expensive than semi-private accommodations, the amount taken into account for purposes of payment under this title with respect to such services may not exceed the amount that would be taken into account with respect to such services if furnished in such semi-private accommodations unless the more expensive accommodations were required for medical reasons

* * * * * * *

(3) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) or [post-hospital] extended care services is in accommodations other than, but not more expensive than, semi-private accommodations and the use of such other accommodations rather than semi-private accommodations was neither at the request of the patient nor for a reason which the Secretary determines is consistent with the purposes of this title, the amount of the payment with respect to such bed and board under part A shall be the amount otherwise payable under this title for such bed and board furnished in semi-private accommodations minus the difference between the charge customarily made by the hospital or skilled nursing facility for bed and board in semi-private accommodations and the charge customarily made by it for bed and board in the accommodations furnished.

* * * * * * *

[Post-Hospital] Extended Care in Christian Science Skilled Nursing Facilities

(y)(1) The term "skilled nursing facility" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, but only [(except for purposes of subsection (a)(2))] with respect to items and services ordinarily furnished by such an institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations.

(2) Notwithstanding any other provision of this title, payment under part A may not be made for services furnished an individual in a skilled nursing facility to which paragraph (1) applies unless such individual elects, in accordance with regulations, for a [spell of illness] to have such services treated as [post-hospital] extended care services for purposes of such part; and payment under part A may not be made for [post-hospital] extended care services—

(A) furnished an individual during such [spell of illness] *year* in a skilled nursing facility to which paragraph (1) applies after—

(i) such services have been furnished to him in such a facility for 30 days during such [spell] *year,* or

(ii) such services have been furnished to him during such [spell] *year* in a skilled nursing facility to which such paragraph does not apply; or

(B) furnished an individual during such [spell of illness] *year* in a skilled nursing facility to which paragraph (1) does not apply after such services have been furnished to him during such [spell] *year* in a skilled nursing facility to which such paragraph applies.

(3) The amount payable under part A for [post-hospital] extended care services furnished an individual during any [spell of illness] *year* in a skilled nursing facility to which paragraph (1) applies shall be reduced by a coinsurance amount [equal to one-eighth of the inpatient hospital deductible for each day before the 31st day] *equal to the coinsurance amount established under section 1813(a)(3)(C) for each day before the 8th day* on which he is furnished such services in such a facility during such [spell] *year* and the reduction under this paragraph shall be in lieu of any reduction under section 1813(a)(3)).

[(4) For purposes of subsection (i), the determination of whether services furnished by or in an institution described in paragraph (1) constitute post-hospital extended care services shall be made in accordance with and subject to such conditions, limitations, and requirements as may be provided in regulations.]

* * * * * * *

In-Home Care; Chronically Dependent Individual

(ff)(1) The term 'in-home care" means the following items and services furnished, under the supervision of a registered professional nurse, to a chronically dependent individual (as defined in paragraph (2)) by a home health agency or by others under arrangments with them made by such agency in a place of residence used as such individual's home:

(A) Services of a homemaker/home health aide (who has successfully completed a training program approved by the Secretary).

(B) Personal care services.

(C) Nursing care provided by a licensed professional nurse.

(2) The term "chronically dependent individual" means an individual who—

(A) is dependent on a daily basis on a primary caregiver who is living with the individual and is assisting the individual without monetary compensation in the performance of at least 2 of the activities of daily living (described in paragraph (3)), and

(B) without such assistance could not perform such activities of daily living.

(3) The "activities of daily living", referred to in paragraph (2), are as follows:

(i) Eating.

(ii) Bathing.

(iii) Dressing.

(iv) Toileting.

(v) Transfering in and out of a bed or in and out of a chair.

EXCLUSIONS FROM COVERAGE

SEC. 1862. (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) which, except for items and services described in [subparagraph (B), (C), or (D)] *a succeeding subparagraph of this paragraph,* are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member,

(B) in the case of items and services described in section 1861(s)(10), which are not reasonable and necessary for the prevention of illness,

(C) in the case of hospice care, which are not reasonable and necessary for the palliation or management of terminal illness,

(D) in the case of clinical care items and services provided with the concurrence of the Secretary and with respect to research and experimentation conducted by, or under contract with, the Prospective Payment Assessment Commission or the Secretary, which are not reasonable and necessary to carry out the purposes of section 1886(e)(6), [and]

(E) in the case of research conducted pursuant to section 1875(c), which is not reasonable and necessary to carry out the purposes of that section; *and*

(F) in the case of in-home care for chronically dependent individuals, which is not reasonable and necessary to assure the health and condition of the individual is maintained in the individual's noninstitutional residence;

* * * * * * *

(6) which constitute personal comfort items (except, in the case of hospice care, as is otherwise permitted under paragraph (1)(C) *and except, in the case of in-home care, as is otherwise permitted under paragraph (1)(F);*

* * * * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) * * *

* * * * * * *

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1813(a)(1), (a)(3) or (a)(4), section 1833(b), or section 1861(v)(3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider) *the amount of any deduction imposed pursuant to section 1833(m)(1) with respect to covered outpatient drugs,* and (ii) an amount equal to so 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1988(c)(1), clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section. A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1861(s)(10)(A), with respect to items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion), and with respect to clinical diagnostic laboratory tests for which payment is made under part B or which are durable medical equipment furnished as home health services. *A provider of services may not impose a charge under the first sentence of this subparagraph for services for which payment is made to the provider pursuant to section 1833(f) (relating to catastrophic benefits.).*

* * * * * * *

(b) An agreement with the Secretary under this section may be terminated—

(1) * * *

* * * * * * *

(3) in the case of inpatient hospital services (including inpatient psychiatric hospital services) or [post-hospital] extended care services, with respect to services furnished after the effective date of such termination, except that payment may be made for up to thirty days with respect to inpatient institutional services furnished to any eligible individual who was admitted to such institution prior to the effective date of such termination,

* * * * * * *

(d) If the Secretary finds that there is a substantial failure to make timely review in accordance with section 1861(k) of long-stay cases in a hospital or skilled nursing facility, he may, in lieu of terminating his agreement with such hospital or facility, decide that, with respect to any individual admitted to such hospital or facility after a subsequent date specified by him, no payment shall be made under this title for inpatient hospital services (including inpatient psychiatric hospital services) after the 20th day of a continuous period of such services or for [post-hospital] extended care services after such day of a continuous period of such care as is prescribed in or pursuant to regulations, as the case may be. Such decision may be made effective only after such notice to the hospital, or (in the case of a skilled nursing facility) to the facility and the hospital or hospital with which it has a transfer agreement, and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the Secretary finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur. The Secretary shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

* * * * * * *

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SEC. 1876. (a)(1)(A) * * *

* * * * * * *

(c)(1) * * *

* * * * * * *

(8) In the case of an individual who enrolls as a member of an eligible organization under this section after January 1 of a year, the organization must take into account, in computing the expenses incurred for covered outpatient drugs for purposes of meeting the deductible under section 1833(m)(1)(A) for the year, expenses incurred for covered outpatient drugs during the year while the individual was entitled to benefits under part B but before the individual so enrolled.

* * * * * * *

VOLUNTARY CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES

SEC. 1882. (a) * * *

(b)(1) * * *

* * * * * * *

(3) Notwithstanding paragraph (1), in the case of a medicare supplemental policy offered in a State and in effect on January 1, 1988, the policy shall not be deemed to meet the standards and requirements set forth in subsection (c), unless each individual who is entitled to benefits under this title and is a policyholder under such policy on January 1, 1988, is sent a letter by not later than January 31, 1988, that explains—

(A) the improved benefits under this title contained in legislation enacted by the first session of the 100th Congress, and

(B) How these improvements affect the benefits contained in the policies and the premium for the policy.

(4) Notwithstanding paragraph (1), a medicare supplemental policy offered in a State shall not be deemed to meet the standards and requirements set forth in subsection (c), with respect to a advertisement (whether through written, radio, or television medium) used (or, at a State's option, to be used) for the policy in the State, unless the entity issuing the policy provides a copy of each advertisement to the Commissioner of Insurance (or comparable officer identified by the Secretary) of that State for his or her review in accordance with State law.

* * * * * * *

HOSPITAL PROVIDERS OF EXTENDED CARE SERVICES

SEC. 1883. (a) * * *

* * * * * * *

(d) Any agreement with a hospital under this section shall provide that payment for services will be made only for services for which payment would be made as [post-hospital] extended care services if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1866; and any individual who is furnished services, for which payment may be made under an agreement under this section, shall, for purposes of this title (other than this section), be deemed to have received [post-hospital] extended care services in like manner and to the same extent as if the services furnished to him had been [post-hospital] extended care services furnished by a skilled nursing facility under an agreement under section 1866.

* * * * * * *

(f) A hospital which enters into an agreement with the Secretary under this section shall be required to meet those conditions applicable to skilled nursing facilities relating to discharge planning and the social services function (and staffing requirements to satisfy it) which are promulgated by the Secretary under section 1861(j)(15). Services furnished by such a hospital which would otherwise constitute [post-hospital] extended care services if furnished by a skilled nursing facility shall be subject to the same requirements applicable to such services when furnished by a skilled nursing facility except for those requirements the Secretary deter-

mines are inappropriate in the case of these services being furnished by a hospital under this section.

* * * * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

* * * * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * * * *

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a), to—

(i) all individuals—

(I) who are receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV (including individuals eligible under this title by reason of section 402(a)(37), 406(h), or 473(b), or considered by the State to be receiving such aid as authorized under section 414(g)).

(II) with respect to whom supplemental security income benefits are being paid under title XVI or who are qualified severely impaired individuals (as defined in section 1905(q)), or

(III) who are qualified pregnant women or children as defined in section 1905(n);

and, to the extent required under subsection (m)(3), some or all of the individuals described in subsection (l)(1);

* * * * * * *

(C) that if medical assistance is included for any group of individuals described in section 1905(a) who are not described in subparagraph (A) or (E), then—

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be [the same] *no more restrictive than the* methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be [the same] *no more restrictive than the* methodology which would be employed under the

appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;

* * * * * *

(E) [at the option of a State, but] subject to subsection (m)(3), for making medical assistance available for medicare cost-sharing (as defined in section 1905(p)(3)) for qualified medicare beneficiaries described in section 1905(p)(1);

* * * * * * *

(46) provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1137 of this Act; [and]

(47) at the option of the State, provide for making ambulatory prenatal care available to pregnant women during a presumptive eligibility period in accordance with section 1920[.]; [(47)] *(48)* provide a method of making cards evidencing eligibility for medical assistance available to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address[.]; *and*

(49)(A) meet the requirements of section 1921 (relating to protection of community spouses), and (B) meet the requirement of section 1917(c) (relating to transfer of assets).

* * * * * * *

The requirement of clause (A) of paragraph (37) with respect to a State plan may be waived by the Secretary if he finds that the State has exercised good faith in trying to meet such requirement. For purposes of this title, any child who meets the requirements of paragraph (1) or (2) of section 473(b) shall be deemed to be a dependent child as defined in section 406 and shall be deemed to be a recipient of aid to families with dependent children under part A of title IV in the State where such child resides. Notwithstanding paragraph (10)(B) or any other provision of this subsection, a State plan shall provide medical assistance with respect to an alien who is not lawfully admitted for permanent residences or otherwise permanently residing in the United States under color of law only in accordance with section 1903(v). *For purposes of paragraph (10), methodology is considered to be "no more restrictive" if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.*

* * * * * *

DEFINITIONS

SEC. 1905. For purposes of this title—

(a) * * *

* * * * * * *

(p)(1) The term "qualified medical beneficiary" means an individual—

(A) who is entitled to hospital insurance benefits under part A of title XVIII (including an individual entitled to such benefits pursuant to an enrollment under section 1818),

(B) who, but for section 1902(a)(10)(E) [and the election of the State], is not eligible for medical assistance under the plan,

(C) whose income (as determined under section 1612 for purposes of the supplemental security income program) does not exceed an income level established by the State consistent with paragraph [(2)(A)] *(2),* and

(D) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed [(except as provided in paragraph (2)(B))] *twice* the maximum amount of resources that an individual may have and obtain benefits under that program.

[(2)(A)] *(2)* The income level established under paragraph (1)(C) [may not exceed a percentage (not more than 100 percent) of the nonfarm] *shall be 100 percent of the* official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

[(B) In the case of a State that provides medical assistance to individuals not described in section 1902(a)(10)(A) and at the State's option, the State may use under paragraph (1)(D) such resource level (which is higher than the level described in that paragraph) as may be applicable with respect to individuals described in paragraph (1)(A) who are not described in section 1902(a)(10)(A).]

(3) The term "medicare cost-sharing" means the following costs incurred with respect to a qualified medicare beneficiary:

(A) Premiums [under part B and (if applicable) under section 1818] *under title XVIII (including under part B and, if applicable, under section 1818).*

[(B) Deductibles and coinsurance described in section 1813.

[(C) The annual deductible described in section 1833(b).]

(B) Coinsurance under title XVIII (including coinsurance described in section 1813).

(C) Deductibles established under title XVII (including those described in section 1813 and 1833(b) and, subject to paragraph (4), the annual deductible under section 1833(m)(1)).

(D) The difference between the amount that is paid under section 1833(a) and the amount that would be paid under such section if any reference to "80 percent" therein were deemed a reference to "100 percent".

Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1876.

(4) Instead of providing to qualified medicare beneficiaries, under paragraph (3)(C), medicare cost-sharing with respect to the annual deductible for covered outpatient drugs under section 1833(m) (1), a State may provide to such beneficiaries, before charges for covered outpatient drugs for a year reach such deductible amount, benefits for prescribed drugs in the same amount, duration, and scope as the benefits made available under the State plan for individuals described in subsection (a) (10) (A) (i).

(5) Notwithstanding any other provision of this title, in the case of a State (other than the 50 States and the District of Columbia)—

(A) the requirement stated in section 1902(a) (10) (E) shall be optional, and

(B) for purposes of paragraph (2) (A), the State may substitute for 100 percent any lesser percentage.

* * * * * * *

LIENS, ADJUSTMENTS AND RECOVERIES, AND TRANSFERS OF ASSETS

Sec. 1917. (a) * * *

* * * * * * *

[(c)(1) Notwithstanding any other provision of this title, an individual who would otherwise be eligible for medical assistance under the State plan approved under this title may be denied such assistance if such individual would not be eligible for such medical assistance but for the fact that he disposed of resources for less than fair market value. If the State plan provides for the denial of such assistance by reason of such disposal of resources, the State plan shall specify a procedure for implementing such denial which, except as provided in paragraph (2), is not more restrictive than the procedure specified in section 1613(c) of this Act, and which may provide for a waiver of denial of such assistance in any instance where the State determines that such denial would work an undue hardship.

[(2)(A) In any case where the uncompensated value of disposed of resources exceeds $12,000, the State plan may provide for a period of ineligibility which exceeds 24 months. If a State plan provides for a period of ineligiblity exceeding 24 months, such plan shall provide for the period of ineligiblity to bear a reasonable relationship to such uncompensated value.

[(B)(i) In the case of any individual who is an inpatient in a skilled nursing facility, intermediate care facility, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of his income required for personal needs, and, who at any time during or after the 24-month period immediately prior to application for medical assistance under the State plan, disposed of a home for less than fair market value, the State plan (subject to clause (iii) may provide for a period of ineligibility for medical assistance in accordance with clause (ii).

[(ii) If the State plan provides for a period of ineligibility under clause (i), such plan—

[(I) shall provide that such individual shall be ineligible for all medical assistance for a period of 24 months after the date on which he disposed of such home, except that, in the case where the uncompensated value of the home is less than the average amount payable under the State plan as medical assistance for 24 months of care in a skilled nursing facility, the period of ineligiblity shall be such shorter time as bears a reasonable relationship (based upon the average amount payable

under the State plan as medical assistance for care in a skilled nursing facility) to the uncompensated value of the home, and

[(II) may provide (at the option of the State) that, in the case where the uncompensated value of the home is more than the average amount payable under the State plan as medical assistance for 24 months of care in a skilled nursing facility, such individual shall be ineligible for all medical assistance for a period in excess of 24 months after the date on which he disposed of such home which bears a reasonable relationship (based upon the average amount payable under the State plan as medical assistance for care in a skilled nursing facility) to the uncompensated value of the home.

[(iii) An individual shall not be ineligible for medical assistance by reason of clause (ii) if—

[(I) a satisfactory showing is made to the State (in accordance with any regulations promulgated by the Secretary) that the individual can reasonably be expected to be discharged from the medical institution and to return to that home,

[(II) title to such home was transferred to the individual's spouse or child who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614,

[(III) a satisfactory showing is made to the State (in accordance with any regulations promulgated by the Secretary) that the individual intended to dispose of the home either at fair market value, or for other valuable consideration, or

[(IV) the State determines that denial of eligibility would work an undue hardship.

[(3) In any case where an individual is ineligible for medical assistance under the State plan solely because of the applicability to such individual of the provisions of section 1613(c), the State plan may provide for the eligibility of such individual for medical assistance under the plan if such individual would be so eligible if the State plan requirements with respect to disposal of resources applicable under paragraphs (1) and (2) of this subsection were applied in lieu of the provisions of section 1613(c).]

(c)(1) In order to meet the requirements of this subsection (for purposes of section 1902(a)(49)(B)), the State plan must provide for a period of ineligibility in the case of an institutionalized individual (as defined in paragraph (3)) who, at any time during the 24-month period immediately before the individual's application for medical assistance under the State plan, disposed of resources for less than fair market value. The period of ineligibility shall begin with the month in which such resources were transferred and the number of months in such period shall be equal to (A) the total uncompensated value of the resources so transferred, divided by (B) the average cost, to a private patient at the time of the application, of nursing home care in the State or, at State option, in the community in which the individual is institutionalized.

(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

(A) the resources transferred were a home and title to the home was transferred to the individual's spouse or child who is under age 21, or (with respect to State eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614;

(B) the resources were transferred to (or to another for the sole benefit of) the community spouse, as defined in section 1921(g)(2);

(C) a satisfatory showing is made to the State (in accordance with any regulations promulgated by the Secretary) that the individual intended to dispose of the resources either at fair market value, or for other valuable consideration; and

(D) the State determines that denial of eligibility would work an undue hardship.

(3) In this subsection, the term "institutionalized individual" means an individual who—

(A) is an inpatient in a skilled nursing facility, intermediate care facility, or other medical institution and

(B) is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs.

(4) A State may not provide for any period of ineligibility for an institutionalized individual due to transfer of resources for less than fair market value except in accordance with this subsection.

TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES

SEC. 1921. (a) SPECIAL TREATMENT FOR INSTITUTIONALIZED SPOUSES.—

(1) SUPERSEDES OTHER PROVISIONS.—In determining the eligibility for medical assistance of an institutionalized spouse (as defined in subsection (g)(1)), the provisions of this section supersede any other provision of this title (including sections 1902(a)(17) and 1902(f)) which is inconsistent with them.

(2) NO COMPARABLE TREATMENT REQUIRED.—Any different treatment provided under this section for institutionalized spouses shall not, by reason of paragraph (10) or (17) of section 1902(a), require such treatment for other individuals.

(3) DOES NOT AFFECT CERTAIN DETERMINATIONS.—Except as this section specifically provides, this section does not apply to—

(A) the determination of what constitutes income or resources, or

(B) the methodology and standards for determining and evaluating income and resources.

(4) ELECTION TO USE OTHER RULES.—An institutionalized spouse may elect not to have this section (other than subsection (c)) apply but to have the spouse's resources and income determined under the law, practice, or policy of the plan (whether

approved or not) in effect on March 1, 1987, except to the extent inconsistent with subsection (c).

(5) APPLICATION IN CERTAIN STATES AND TERRITORIES.—

(A) APPLICATION IN STATES OPERATING UNDER DEMONSTRATION PROJECTS.—In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title XIX.

(B) NO APPLICATION IN COMMONWEALTHS AND TERRITORIES.—This section shall only apply to a State that is one of the 50 States or the District of Columbia.

(b) RULES FOR TREATMENT OF INCOME.—

(1) SEPARATE TREATMENT OF INCOME.—During any month in which an institutionalized spouse is in the institution, no income of the community spouse shall be deemed available to the institutionalized spouse.

(2) ATTRIBUTION OF INCOME.—In determining the income of an institutionalized spouse or community spouse, except as otherwise provided in this section and regardless of any State laws relating to community property or the division of marital property, the following rules apply:

(A) NON-TRUST PROPERTY.—Subject to subparagraphs (C) and (D), in the case of income not from a trust, unless the instrument providing the income otherwise specifically provides—

(i) if payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

(ii) if payment of income is made in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

(iii) if payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each of the individuals named in equal proportional shares.

(B) TRUST PROPERTY.—In the case of a trust—

(i) except as provided in clause (ii), income shall be attributed in accordance with the provisions of this title (including sections 1902(a)(17) and 1902(k)), and

(ii) unless the trust otherwise specifically provides—

(I) if payment of income is made solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

(II) if payment of income is made to both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

(III) if payment of income is made to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each of such individuals in equal proportional shares.

(C) PROPERTY WITH NO INSTRUMENT.—In the case of income not from a trust in which there is no instrument establishing ownership, subject to subparagraph (D), one-half of the income shall be considered to be available to the institutionalized spouse and one-half to the community spouse.

(D) REBUTTING OWNERSHIP.—The rules of subparagraphs (A) and (C) are superceded to the extent that an institutionalized spouse can establish, by a preponderance of the evidence, that the ownership interests in income are other than as provided under such subparagraphs.

(c) RULES FOR TREATMENT OF RESOURCES.

(1) COMPUTATION OF SPOUSAL SHARE AT TIME OF INSTITUTIONALIZATION.—There shall be computed (as of the beginning of a continuous period of institutionalization of the institutionalized spouse) a spousal share which is equal to ½ of the value of all the resources held by either the institutionalized spouse, community spouse, or both.

(2) ATTRIBUTION OF RESOURCES AT TIME OF INITIAL ELIGIBILITY DETERMINATION.—In determining the resources of an institutionalized spouse at the time of application for benefits under this title, regardless of any State laws relating to community property or the division of marital property—

(A) except as provided in subparagraph (B), all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse, and

(B) resources held in the name of (or for the sole benefit of) the community spouse shall not be considered to be available to an institutionalized spouse, to the extent that the amount of such resources does not exceed the amount computed under subsection (e)(2)(A) (as of the time of application for benefits), or, if greater, the amount that a court has ordered to be retained by the community spouse for the support of the community spouse.

(3) SEPARATE TREATMENT OF RESOURCES AFTER ELIGIBILITY FOR BENEFITS ESTABLISHED.—During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be eligible for benefits under this title, no resources of the community spouse shall be deemed available to the institutionalized spouse.

(4) RESOURCES DEFINED.—In this section, the term "resources" does not include resources excluded under subsection (a) or (d) of section 1613 and does not include resources that would be excluded under section 1613(a)(2)(A) but for the limitation on total value described in such section.

(c) PROTECTING INCOME FOR COMMUNITY SPOUSE.—

(1) ALLOWANCES TO BE OFFSET FROM INCOME OF INSTITUTIONALIZED SPOUSE.—After an institutionalized spouse is determined to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

(A) A personal needs allowance that is reasonable in amount for clothing and other personal needs of the institutionalized spouse and which is not less than $25 per month.

(B) A community spouse monthly income allowance (as defined in paragraph (2)), but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse.

(C) A family allowance, for each family member, equal to at least one-third of the amount by which the amount described in paragraph (3)(A)(i) exceeds the amount of the montly income of that family member.

(D) Amounts for incurred expenses for medical or remedial care for the institutionalized spouse that are not subject to payment by a legally liable third party.

In subparagraph (C), the term "family member" only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

(2) COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE DEFINED.—In this section (except as provided in paragraph (6)), the "community spouse montly income allowance" for a community spouse is an amount by which—

(A) except as provided in paragraph (4), the minimum monthly maintenace needs allowance (established under and in accordance with paragraph (3)) for the spouse, exceeds

(B) the amount of montly income otherwise available to the community spouse (determined without regard to such an allowance).

(3) ESTABLISHMENT OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—

(A) IN GENERAL.—Each State shall establish a minimum monthly maintenance needs allowance for each community spouse which, subject to subparagraph (B), is equal to or exceeds—

(i) 150 percent of one-twelfth of the nonfarm income official poverty line (defined by the Office of Management and Budget and revised annually in accordance with sections 652 and 673(2) of the Omnibus Budget Reconciliation Act of 1981) for a family unit of 2 members; plus

(ii) an excess shelter allowance (as defined in paragraph (5)); plus

(iii) one-half of the amount by which the income available to the institutionalized spouse exceeds the sume of the amounts described in clauses (i) and (ii).

A revision of the official poverty line referred to in clause (i) shall apply to medical assistance furnished during and after the second calendar quarter that begins after the date of publication of the revision.

(B) CAP ON MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—The minimum monthly maintenance needs allowance established under subparagraph (A) may not exceed $1,500 (subject to adjustment under subsection (f)).

(4) NOTICE AND FAIR HEARING.—

(A) NOTICE.—Upon—

(i) a determination of eligiblity for medical assistance of an institutionalized spouse, or

(ii) a request by an institutionalized spouse (or community spouse or representative on the spouse's behalf),

each State shall notify the spouse of the amount of the community spouse monthly income allowance (described in paragraph (1)(B)), of the amount of any family allowances (described in paragraph (1)(c)), of the method for computing the amount of the community spouse resources allowance permitted under subsection (e), and of the spouse's right to a fair hearing under subparagraph (B) respecting the determination of the community spouse monthly income allowance.

(B) FAIR HEARING.—If an institutionalized spouse is dissatisfied with a determination of—

(i) the community spouse monthly income allowance because the amount of the minimum monthly maintenance needs allowance (established under paragraph (3)) is not adequate to support the community spouse without financial duress, or

(ii) the amount of monthly income otherwise available to the community spouse (as applied under paragraph (2)(B)),

the institutionalized spouse is entitled to a fair hearing described in section 1902(a)(3) with respect to such determination. If the institutionalized spouse establishes that the minimum monthly maintenance needs allowance is not adequate to support the community spouse without financial duress, there shall be substituted, for the minimum monthly maintenance needs allowance in paragraph (2)(A), an amount adequate to support the community spouse without financial duress.

(5) EXCESS SHELTER ALLOWANCE DEFINED.—In paragraph (3)(A)(ii), the term "excess shelter allowance" means, for a community spouse, the amount by which the sum of—

(A) the spouse's expenses for mortgage payment (including principal, interest, taxes, and insurance and, in the case of a condominium or cooperative, required maintenance charge) or rent, and

(B) the standard utility allowance (used by the State under section 5(e) of the Food Stamp Act of 1977) or, if the State does not use such an allowance, the spouse's actual utility expenses,

exceeds 30 percent of the amount described in paragraph (3)(A)(i), except that, in the case of a condominium or cooperative, for which a maintenance charge is included under subparagraph (A), any allowance under subparagraph (B) shall be reduced to the extent the maintenance charge includes utility expenses.

(6) COURT ORDERED SUPPORT.—If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly income so ordered.

(e) PERMITTING TRANSFER OF RESOURCES TO COMMUNITY SPOUSE.—

(1) IN GENERAL.—An institutionalized spouse may, without regard to section 1917, transfer to the community spouse (or to another for the sole benefit of the community spouse) an amount equal to the community spouse resource allowance (as defined in paragraph (2)), but only to the extent the resources of the institutionalized spouse are transferred to (or for the sole benefit of) the community spouse.

(2) COMMUNITY SPOUSE RESOURCE ALLOWANCE DEFINED.—In paragraph (1), the "community spouse resource allowance" for a community spouse is an amount (if any) by which—

(A) the greater of—

(i) $12,000 (subject to adjustment under subsection (f)), or

(ii) the lesser of (I) the spousal share computed under subsection (c)(1), or (II) 4 times the amount described in clause (i), exceeds

(B) the amount of the resources otherwise available to the community spouse (determined without regard to such an allowance).

(3) TRANSFERS UNDER COURT ORDERS.—If a court has enterned an order against an institutionalized spouse for the support of the community spouse, section 1917 shall not apply to amounts of resources transferred pursuant to such order for the support of the spouse of a family member (as defined in subsection (d)(1)).

(f) INDEXING DOLLAR AMOUNTS.—For services furnished during a calendar year after 1988, the dollar amounts specified in subsections (d)(3)(B) and (e)(2)(A)(i) shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between September 1987 and the September before the calendar year involved.

(g) DEFINITIONS.—In this section:

(1) The term "institutionalized spouse" means an individual who—

(A) is in a hospital, skilled nursing facility, or intermediate care facility, or who (at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI), and

(B) is married to a spouse who is not in a hospital, skilled nursing facility, or intermediate care facility; but does not include any such individual who is not likely to

meet the requirements of subparagraph (A) for at least 30 consecutive days.

(2) The term "community spouse" means the spouse of an institutionalized spouse.

REFERENCES TO LAWS DIRECTLY AFFECTING MEDICAID PROGRAM

SEC. [1921] *1922.* (a) AUTHORITY OR REQUIREMENTS TO COVER ADDITIONAL INDIVIDUALS.—For provisions of law which make additional individuals eligible for medical assistance under this title, see the following:

(1) AFDC.—(A) Section 402(a)(32) of this Act (relating to individuals who are deemed recipients of aid but for whom a payment is not made). Section 402(a)(37) of this Act (relating to individuals who lose AFDC eligibility due to increased earnings).

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INTERNAL REVENUE CODE OF 1986

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Subtitle A—Income Taxes

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CHAPTER 1—NORMAL TAXES AND SURTAXES

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Subchapter A—Determination of Tax Liability

Part I. Tax on individuals.

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Part VIII. Supplemental medicare premium.

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PART VIII—SUPPLEMENTAL MEDICARE PREMIUM

See. 59B. Imposition of supplemental medicare premium.

SEC. 59B. IMPOSITION OF SUPPLEMENTAL MEDICARE PREMIUM.

(a) IMPOSITION OF PREMIUM.—In the case of a medicare-eligible individual, there is hereby imposed (in addition to any other amount imposed by this subtitle) for each taxable year a premium equal to the annual premium for such year determined under subsection (b).

(b) DETERMINATION OF AMOUNT.—For purposes of this section—

(1) IN GENERAL.—Except as otherwise provided in this subsection—

If the adjusted gross income for the taxable year is:

Over:	But not over:	The annual premium for the taxable year is:
$0	$6,000	$0
6000	6,143	10
6,143	6,287	20
6,287	6,430	30
6,430	6,573	40
6,573	6,716	50
6,716	6,860	60
6,860	7,003	70
7,003	7,146	80
7,146	7,289	90
7,289	7,433	100
7,433	7,576	110
7,576	7,719	120
7,719	7,862	130
7,862	8,006	140
8,006	8,149	150
8,149	8,292	160
8,292	8,436	170
8,436	8,579	180
8,579	8,722	190
8,722	8,865	200
8,865	9,009	210
9,009	9,152	220
9,152	9,295	230
9,295	9,438	240
9,438	9,582	250
9,582	9,725	260
9,725	9,868	270
9,868	10,011	280
10,011	10,155	290
10,155	10,298	300
10,298	10,441	310
10,441	10,585	320
10,585	10,728	330
10,728	10,871	340
10,871	11,014	350
11,014	11,158	360
11,158	11,301	370
11,301	11,444	380
11,444	11,587	390
11,587	11,731	400
11,731	11,874	410
11,874	12,017	420
12,017	12,160	430
12,160	12,304	440
12,304	12,447	450
12,447	12,590	460
12,590	12,734	470
12,734	12,877	480
12,877	13,020	490
13,020	13,163	500
13,163	13,307	510
13,307	13,450	520
13,450	13,593	530
13,593	13,736	540
13,736	13,880	550
13,880	14,023	560
14,023	14,166	570
14,166		580.

(2) SPECIAL RULE WHERE INDIVIDUAL NOT ELIGIBLE FOR ENTIRE TAXABLE YEAR; SHORT TAXABLE YEARS.—If an individual is not a medicare-eligible individual for each month during his taxable year, the annual premium determined under this subsection shall be an amount which bears the same ratio to the amount determined under paragraph (1) as—

(A) the number of months during the taxable year for which such individual is a medicare-eligible individual, bears to

(B) 12.

A similar rule shall apply in the case of a taxable year of less than 12 months; except that adjusted gross income for the taxable year shall be annualized.

(3) SPECIAL RULE FOR JOINT RETURNS.—In the case of a joint return—

(A) this section shall be applied separately with respect to each spouse, and

(B) the adjusted gross income of each spouse shall be ½ of their combined adjusted gross income.

(4) ADJUSTMENTS TO TABLE.—

(A) IN GENERAL.—Not later than December 15 of 1988 and each subsequent calendar year, the Secretary shall prescribe a table which shall apply in lieu of the table contained in paragraph (1) with respect to taxable years beginning in the succeeding calendar year.

(B) METHOD OF PRESCRIBING TABLE.—The table which, under subparagraph (A), is to apply in lieu of the table contained in paragraph (1) with respect to taxable years beginning in any calendar year shall be prescribed—

(i) by increasing each dollar amount setting forth the amount of the premium in such table by the medicare inflation factor for such calendar year, and

(ii) by increasing each other dollar amount in such table by the cost-of-living adjustment for such calendar year (as defined in section 1(f)(3)).

(C) MEDICARE INFLATION FACTOR.—For purposes of subparagraph (B), the medicare inflation factor for any calendar year is the percentage (if any) by which—

(i) the medicare value for such calendar year, exceeds

(ii) the medicare value for 1988.

(D) ROUNDING.—If any increase determined under subparagraph (B) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

(c) DEFINITIONS AND SPECIAL RULES.—

(1) MEDICARE-ELIGIBLE INDIVIDUAL.—For purposes of this section—

(A) IN GENERAL.—Except as otherwise provided in this paragraph, the term "medicare-eligible individual" means, with respect to any month, any individual who is entitled to (or, on application without the payment of an additional premium, would be entitled to) benefits under part A of title XVIII of the Social Security Act for such month.

(B) EXCEPTIONS.—The term "medicare-eligible individual" shall not include for any month—

(i) any individual who is entitled to benefits under part A of title XVIII of the Social Security Act for such month solely by reason of the payment of a premium under section 1818 of such Act,

(ii) any individual who is required to pay a premium for such month increased or computed under paragraph (4) or (5) of section 1839(e) of the Social Security Act, or

(iii) any qualified nonresident.

(C) TREATMENT OF INDIVIDUALS WHO HAVE ATTAINED AGE 65.—An individual (other than nonresident alien) who has attained age 65 shall be treated as a medicare-eligible individual for the month in which he attains age 65 and any subsequent month unless such individual establishes to the satisfaction of the Secretary that he is not a medicare-eligible individual for the month concerned.

(2) MEDICARE VALUE.—

(A) IN GENERAL.—For purposes of this section, the term "medicare value" means, for any calendar year, the sum of the Medicare Part A value for January of such calendar year and the Medicare part B valve for January of such calendar year.

(B) MEDICARE PART A VALUE.—For purposes of subparagraph (A), the term "Medicare part A value" means, with respect to any month, an amount equal to 50 percent of the monthly acturial rate promulgated under section 1818(d)(1) of the Social Security Act for such month.

(C) MEDICARE PART B VALUE.—For purposes of subparagraph (A), the term "Medicare part B value" means, with respect to any month, an amount equal to the excess of—

(i) the amount equal to twice the monthly actuarial rate established under section 1839(a)(1) of the Social Security Act for the calendar year which includes such month, over

(ii) the amount of the monthly premium for such month established under section 1839 of such Act (without regard to subsections (b), (e)(4), (e)(5), and (f) thereof).

(3) QUALIFIED NONRESIDENT.—

(A) IN GENERAL.—For purposes of paragraph (1), the term "qualified nonresident" means, with respect to any month during the taxable year, any individual if—

(i) such individual is not furnished during such taxable year or any of the 4 preceding taxable years any service for which a claim for payment is or will be made under part A of title XVIII of the Social Security Act,

(ii) such individual is not entitled to benefits under part B of title XVIII of the Social Security Act at any time during such taxable year or any of the 4 preceding taxable years, and

(iii) suh individual is present in a foreign country or countries for at least 330 full days during—

(I) the 12-month period ending at the close of the taxable year, and

(II) each of the 4 consecutive preceding 12-month periods.

(B) SPECIAL RULE FOR INDIVIDUALS WHO DIE DURING THE TAXABLE YEAR.—An individual who dies during the taxable year shall be treated as meeting the requirement of subparagraph (A)(iii)(I) if such individual is present in a foreign country or countries for at least a number of full days equal to 90 percent of the days during such taxable year before the date of death.

(4) COORDINATION WITH OTHER PROVISIONS.—

(A) NOT TREATED AS MEDICAL EXPENSE.—The premium imposed by this section shall not be treated as an expense paid for medical care for purposes of section 213.

(B) NOT TREATED AS TAX FOR CERTAIN PURPOSES.—The premium imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

(i) the amount of any credit allowable under this chapter, or

(ii) the amount of the minimum tax imposed by section 55.

(C) TREATED AS TAX FOR SUBTITLE F.—For purposes of subtitle F, the premium imposed by this section shall be treated as if it were a tax imposed by section 1.

(D) SECTION 15 NOT TO APPLY.—Section 15 shall not apply to the premium imposed by this section.

* * * * * * *

Subtitle F—Procedure and Administration

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CHAPTER 61—INFORMATION AND RETURNS

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Subchapter A—Returns and Records

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PART III—INFORMATION RETURNS

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Subchapter B—Information Concerning Transactions With Other Persons

Sec. 6041. Information at source.

* * * * * * *

Sec. 6050O. Returns relating to individuals entitled to receive benefits under Medicare part A.

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SEC. 60500. RETURNS RELATING TO INDIVIDUALS ENTITLED TO RECEIVE BENEFITS UNDER MEDICARE PART A.

The Secretary of Health and Human Services shall make a return (at such times and in such form as the Secretary may prescribe) setting forth the name, address, and TIN of each individual who is entitled to receive benefits (other than by reason of the payment of a premium referred to in clause (i) or (ii) of section 59B(c)(1)(B)) under part A of title XVIII of the Social Security Act for any month during the calendar year and the number of months in the calendar year for which the individual is so entitled.

* * * * * * *

SECTION 9403 OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1986

SEC. 9403. OPTIONAL COVERAGE OF POOR MEDICARE BENEFICIARIES FOR MEDICARE COST-SHARING EXPENSES.

(a) * * *

* * * * * * *

(g) CONFORMING AMENDMENTS.—

(1) TREATMENT OF BENEFITS.—Section 1902(a)(10)(C) of such Act (42 U.S.C. 1396a(a)(10((C)) is amended, in the matter before clause (i), by inserting "or (E)" after "subparagraph (A)".

[(2) PAYMENT OF MEDICARE PREMIUMS AND PART A DEDUCTIBLE.—Section 1903(a)(1) of such Act (42 U.S.C. 1396b(a)(1)) is amended—

[(A) by inserting "deductible amounts under part A and" after "(including expenditures for",

[(B) by inserting "(and, in the case of qualified medicare beneficiaries described in section 1905(p)(1), part A)" after "premiums under part B", and

[(C) by striking "or (B)" and inserting "(B) are qualified medicare beneficiaries described in section 1905(p)(1), or (C)".]

(2) PAYMENT OF MEDICARE COST-SHARING.—Section 1903(a)(1) of such Act (42 U.S.C. 1396b(a)(1)) is amended by inserting "including expenditures for medicare cost-sharing and" before "including expenditures.".

* * * * * * *

SECTION 2355 OF THE DEFICIT REDUCTION ACT OF 1984

WAIVERS FOR SOCIAL HEALTH MAINTENANCE ORGANIZATIONS

SEC. 2355. (a) * * *

(b) A project referred to in subsection (a) is a project—

(1) * * *

* * * * * * *

(5) under which all payors will share risk for no more than two years, with the organization being at full risk in the third year *and in succeeding years;*

* * * * * * *

(d)(1) The Secretary of Health and Human Services shall submit a preliminary report to the Congress on the status of the projects and waivers referred to in subsection (a) 45 days after the date of the enactment of this Act.

(2) The Secretary shall submit a [final] *interim* report to the Congress on the projects referred to in subsection (a) not later than 42 months after the date of the enactment of this Act.

Dissenting Views on H.R. 2470—Medicare Catastrophic Protection Act

No one will argue that it is not a worthwhile task to devise a financing mechanism to reduce the risks involved with serious illness. For that reason, President Reagan received bipartisan support when he submitted legislation to Congress providing full acute care coverage to Medicare beneficiaries. Unfortunately, what began as an actuarially sound, simple reform to the Federal insurance program for the elderly has resulted in a broad expansion of Medicare benefits (largely for non-catastrophic care) financed through substantial increases in the program's existing premiums and by adding a new mandatory premium (which is essentially a tax) for nearly half of the program's beneficiaries.

The legislation considered by the Committee on Energy and Commerce, H.R. 2470 (as reported by the Committee on Ways and Means), may be titled the Medicare Catastrophic Protection Act of 1987, but its five-year program cost of $24 billion and estimated revenues from new taxes of over $26 billion should be considered the real catastrophe. Regretfully, this Committee's amending process further increased program outlays by an additional $13 billion over five years according to the Congressional Budget Office. These additional costs will result in nearly half of elderly beneficiaries experiencing a five-fold increase in their annual Medicare premiums.

To support this legislation is to do a great disservice to the elderly of this country. The value of the new benefits established in H.R. 2470 may not be proportionate to the substantial increase in premiums which millions of individuals over 65 will be mandated to pay. We opposed reporting H.R. 2470 when it was considered by the Committee because of the substantial increase in beneficiary premiums and program outlays. We strongly believe that a major expansion of the Medicare program will jeopardize its long-term solvency.

Because Title I of H.R. 2470 is not under the jurisdiction of the Committee on Energy and Commerce, we could make no changes to the provision in Title I which requires all tax-paying individuals eligible for Medicare to pay a supplemental premium. Though called a premium, it is mandatory, not deductible as a health care expense and collected by the Internal Revenue Service. The maximum surtax, as the premium is better known, is $580 in the first year alone and the Department of Treasury estimates it will increase to $830 in 1991. An elderly couple with an adjusted gross income of $34,000 would face a $1,160 increase to their current tax liability of approximately $2,700. We cannot support such a steep increase in premium payments when they have no direct relationship to the use or value of the increase in benefits established by the bill.

Additionally, this legislation greatly expands Medicare benefits for non-acute care catastrophic benefits, which may be worthwhile, but not appropriate for inclusion in Medicare catastrophic legislation. H.R. 2470 expands the current limit on outpatient mental health services, provides a new benefit for in-home care by a home health aide or homemaker, and allows that the expenses for certain routine cancer screening be included in the catastrophic out-of-pocket Part B limit. These expansions increase both program outlays (Federal spending) and beneficiary cost sharing for benefits that many Medicare eligibles do not consider essential. Regardless of how many of the elderly will utilize these benefits, all will pay for them. Due to the limits in the outyears on premium levels mandated in the legislation, the Federal Government will have to pick up an ever greater proportion of the total bill. If the rate at which costs increase is greater than the rate at which premiums are allowed to increase, the difference will have to come out of general revenues. We believe the elderly rely on Congres to maintain the long-term viability of the Medicare program. Clearly, we cannot justify the many non-acute care benefit expansions included in H.R. 2470 during a time of already astronomical Federal deficits.

Of particular concern to us is the Committee's addition of a catastrophic drug benefit to the Medicare program. The data from the Department of Health and Human Sevices, several States with drug programs, and private insurance companies show a wide variance in utilization and program costs. Many Medicare beneficiaries already pay for private Medigap policies that provide drug coverage and do not want to be saddled with an additional premium that pays for drugs only after a $500 deductible is met. We supported an amendment which would have required States to expand their Medicaid drug programs to include individuals over 65 who are at 200 percent of the Federal poverty level. For this population, the expense of out-patient drug therapy is truly catastrophic and should be provided through Federal and State financing.

In conclusion, we reaffirm our continued support and commitment to Medicare coverage for catastrophic acute care expenses and commend the President for his legislation. By establishing new program benefits in H.R. 2470, Congress has made a promise to the elderly. These programs, together with their funding mechanisms, will not be affordable to beneficiaries in the very near future—making this only a false promise. Therefore, we cannot be party to the legislation reported by this Committee, and we must voice our strong opposition.

Norman F. Lent.
Ed Madigan.
Carlos J. Moorhead.
Bill Dannemeyer.
Tom Tauke.
Dan Coats.
Thomas J. Bliley, Jr.
Jack Fields.
Michael G. Oxley.
Howard C. Nielson.
Dan Schaefer.
Joe Barton.

Calendar No. 260

100TH CONGRESS
1st Session

SENATE

REPORT
100-126

MEDICARE CATASTROPHIC LOSS PREVENTION ACT OF 1987

JULY 27, 1987.—Ordered to be printed

Filed under authority of the order of the Senate of JULY 24 (legislative day, JUNE 23), 1987.

Mr. BENTSEN, from the Committee on Finance, submitted the following

REPORT

[To accompany S. 1127]

The Committee on Finance, to which was referred the bill (S. 1127) to provide for medicare catastrophic illness coverage, and for other purposes, having considered the same, reports favorably thereon with an amendment in the nature of a substitute to the text, and recommends that the bill as amended do pass.

CONTENTS

	Page
I. Background and Need for Legislation	2
II. Explanation of Bill	5
Sec. 1. Short title; References	5
Sec. 2. Scope of benefits under Part A	5
Sec. 3. Deductibles and coinsurance under Part A	6
Sec. 4. Limitations on cost-sharing	7
Sec. 5. Increase in Part B premium	9
Sec. 6. Supplemental premium	10
Sec. 7. Medicare coverage of home health services on a daily basis	12
Sec. 8. Clarification of requirement that individual be confined to home to be eligible for home health services	13
Sec. 9. Annual notice to Medicare beneficiaries	13
Sec. 10. Adjustment of AAPCC's and contracts for risk-based organizations	14
Sec. 11. Study of treatment of prescription drugs	14
Sec. 12. Hospice care	15
Sec. 13. Voluntary certification of Medicare supplemental health insurance policies	15

Sec. 14. Determination of Medicaid savings; State plan requirements ..... Page 18
Sec. 15. Studies of long-term care 19
Sec. 16. Case management demonstration projects 19
Sec. 17. Repeal of authority to administer proficiency examinations 20
Sec. 18. Trustee comments on actuarial soundness of basic and supplemental catastrophic benefit premiums 21
Sec. 19. Technical amendment relating to waivers for home and community-based services 21
Sec. 20. Technical amendments relating to New Jersey respite care pilot project 22
III. Hearings 22
IV. Committee Vote 22
V. Costs of Carrying Out the Bill 22
VI. Regulatory Impact 31
VII. Additional views of Mr. Wallop 33
VIII. Additional views of Mr. Armstrong 37
IX. Changes in Existing Law Made by the Bill, as Reported 40

I. BACKGROUND AND NEED FOR LEGISLATION

The Medicare Catastrophic Loss Prevention Act of 1987 protects Medicare beneficiaries from catastrophic expenses associated with covered Medicare services. This legislation responds to the concern that Medicare, which currently has no upper limit on cost-sharing charges, does not offer protection against catastrophic hospital and physicians expenses.

The Medicare program was designed to meet the acute health care needs of the elderly. Fairly extensive coverage is provided for short-term hospital stays under Medicare Part A. However, coverage for long-term hospital stays is less adequate. These stays are subject to significant coinsurance charges, though less than 1% of beneficiaries face such charges in a given year. Further, a beneficiary may potentially exhaust all hospital benefits.

Beneficiaries enrolled in the Part B program pay a monthly premium ($17.90 in 1987). They are also liable for certain charges in connection with their use of physicians and other services covered under the program. All beneficiaries are liable for the $75 deductible and 20 percent coinsurance charges. In addition, where a physician or other provider does not accept "assignment" (i.e., does not agree to accept Medicare's determination of "reasonable charge" as payment in full for covered services), the beneficiary is liable for the difference between Medicare's reasonable charge and the physician's actual charge. This is commonly referred to as "balance billing."

The Congressional Budget Office estimates that liabilities for Medicare copayments will average $456 in 1987; an additional $105 represents average liability for "balance billing" charges by physicians. Thus total liabilities in connection with covered services are an estimated $561 per enrollee. However, the liability for Medicare cost-sharing charges is not distributed evenly throughout the population. Copayment liabilities are highest for those with inpatient stays and for those with renal disease. Those with hospital stays comprise 22 percent of the enrollee population but are liable for 70 percent of out-of-pocket costs. For those with one inpatient stay, the average liability is $1,335. For the 0.5 percent of enrollees who use some hospital coinsurance days, the average out-of-pocket li-

ability is $7,657. Additionally, enrollees with renal disease comprise only 0.4 percent of enrollees but are liable for 3.7 percent of out-of-pocket costs.

An estimated 72 percent of Medicare beneficiaries have purchased so-called Medigap policies, i.e., private insurance coverage to supplement Medicare's benefit package. The principal protection offered by the majority of these policies is coverage of Medicare's cost-sharing charges. Some policies cover a limited number of additional services not covered by Medicare, such as prescription drugs. Insurance premiums for this protection will average between $500 and $600 in 1987; however both coverage and costs vary considerably among policies. An estimated 8 percent of enrollees are also covered by State Medicaid programs. These programs vary substantially in terms of eligibility, scope of coverage, and payment of benefits, though they generally provide protection against high out-of-pocket payments for dual enrollees.

The elderly with lower incomes and higher health care needs are the least likely to have either private supplementary coverage or Medicaid protection. In 1984, 20 percent of the elderly had no additional coverage. Nearly 30 percent of persons with family incomes below $9,000 were without additional coverage compared to only 10 percent of enrollees with family incomes over $25,000. Although health care needs rise with age, so did the likelihood of being without supplemental private insurance coverage or Medicaid. Seventeen percent of enrollees between age 65 and 69 lacked additional coverage while 27 percent age 80 and over had no such protection.

A number of services used by the elderly are not covered under Medicare. These include prescription drugs, eyeglasses, hearing aids, dentures, and most long-term care services. Beneficiaries are liable, therefore, for health care costs in addition to cost-sharing charges associated with covered Medicare services. In 1984, per capita out-of-pocket payments by the elderly totalled $1,059 or 25 percent of their total health care bill. These amounts do not include the additional amounts spent by the elderly for payment of the Part B premiums or private insurance premiums. It has been estimated that mean out-of-pocket payments (including insurance premiums) as a percentage of mean income was 15 percent in 1984. However, these figures are averages. They may be higher or lower for individual beneficiaries depending on individual circumstances such as age, incidence of acute illness, the presence of chronic conditions, and other insurance coverage. The impact of these expenditures may be particularly severe for those lower income aged without other health coverage.

The Center for Health Policy Studies, Georgetown University School of Medicine, has made projections of the elderly's out-of-pocket expenses for acute care as a percentage of per capita income for 1986. Excluding long-term care costs, the elderly with incomes under $5,000 are estimated to spend 18 percent of their incomes on medical care while those with incomes over $20,000 are estimated to spend only 4 percent of their incomes on medical care. Almost one-quarter (23.8 percent) of elderly persons are estimated to spend over 15 percent of their income on medical bills (not including those for long term care) and 7.7 percent are estimated to spend over 25 percent of their incomes on such bills.

The Committee bill addresses itself to filling the gaps in Medicare's acute care benefits. It is expected that the administrative costs of providing the additional coverage will be substantially less than those currently associated with coverage under Medigap policies. While all who benefit from the new program will pay an additional amount, those with higher incomes will pay more than those with lower incomes.

The bill substantially improves Medicare benefits by adding catastrophic coverage. In developing a funding mechanism for such improvements, the committee followed four basic principles. First, the funding mechanism should cover the cost of the benefit improvements, both in the short-term and the long-term. Second, the committee believed that the cost of the benefit improvements should be borne by those receiving the benefits. Third, the committee believed that all those who benefit from the added coverage should pay something for that coverage, but that the burden be based in part on the ability to pay. Fourth, the committee believed that the receipt of catastrophic coverage, and the payment of the associated premiums, should be on a voluntary basis like current Part B Medicare coverage.

In light of these principles, the committee determined that the catastrophic benefits should be financed by the combination of (1) an increase in the basic Part B monthly premium, and (2) a new income-related supplemental premium collected through the income tax system. Both the basic premium and the income-related premium are indexed directly to increases in the cost of the new catastrophic benefits. This will result in the program being self-financing in the short-term and the long-term.

Under the bill, the Part B premium generally is increased by $4 per month beginning in April of 1988. This additional premium is indexed to the per enrollee cost of the new catastrophic benefit.

The supplemental premium is to be collected only from individuals enrolled in Medicare Part B and with Federal income tax liability greater than or equal to $150. Unlike the existing Part B premium, which is the same for all Part B enrollees regardless of income, the supplemental premium increases according to the enrollee's tax liability. The supplemental premium is $1.02 per month of Part B enrollment per $150 of Federal income tax liability for taxable years beginning before 1989. The supplemental premium is indexed to the per enrollee cost of the new catastrophic benefit.

The supplemental premium is capped so that the sum of the Part B and the maximum supplemental premiums always is less than the value of Part B coverage (including the new catastrophic benefits). The cap is $800 per enrollee in 1988, increasing to $1,000 in 1992. After 1992, the cap is 65 percent of the excess of the value of Medicare Part B coverage over the Part B monthly premium (including the additional Part B premium to fund the new catastrophic benefit).

The Committee recognizes that the bill does not provide protection against the costs associated with noncovered Medicare services such as prescription drugs, long-term care, and balance billing charges. However, the Committee views the bill as an important step in protecting the elderly against high medical expenses.

II. EXPLANATION OF BILL

Section 1. Short Title; Reference in the Act

Explanation of provision.—The provision specifies that the Act may be cited as the "Medicare Catastrophic Loss Prevention Act of 1987". The provision would further specify that the references in the Act, unless otherwise stated, are to the Social Security Act.

Section 2. Scope of Benefits Under Part A

Current law.—Under current law, the scope of inpatient hospital and skilled nursing benefits available to a beneficiary is linked to the individual's benefit period or spell of illness. A benefit period is defined as beginning when a beneficiary enters a hospital or skilled nursing facility and ending when he or she has not been in a hospital or skilled nursing facility for 60 days.

During each spell of illness, the Part A program pays for 60 days of inpatient hospital care subject to a deductible. The beneficiary is entitled to an additional 30 days of care, subject to a daily coinsurance charge. In addition, the beneficiary has a lifetime reserve of 60 days of added coverage (subject to a daily coinsurance charge) after the 90 days have been exhausted. After the beneficiary has received 90 days of care in a benefit period and exhausted the 60 lifetime reserve days, Medicare reimbursement ceases and the beneficiary is liable for all additional hospital charges during that spell of illness.

Under current law, special limits apply to inpatient services in a psychiatric hospital. Payment may not be made for more than 190 days of inpatient hospital services furnished in a psychiatric hospital in an individual's lifetime (the so-called lifetime limit). The Part A program also includes an inpatient psychiatric carryover restriction for individuals who are in a participating psychiatric hospital on the first day of an individual's entitlement. All days during the immediately preceding 150 days during which the individual was an inpatient of a psychiatric hospital are deducted from the initial benefit period. Such days do not count toward the lifetime limit.

During each spell of illness, the Part A program pays for up to 100 days of post-hospital extended care services in a qualified skilled nursing facility (SNF).

SNF services are covered under Medicare only if the individual has been a hospital inpatient for at least three consecutive days and is admitted to the SNF within 30 days after the hospital discharge. Furthermore, the extended care services must have been necessitated by a condition which necessitated the patient's hospital stay. Congress provided in the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248, known as TEFRA) that the Secretary provide for coverage of extended care services that do not follow a hospitalization if the inclusion of such coverage would not result in any increase in the total payments made for extended care services and if it would not alter the acute care nature of the benefit. The Secretary has not used the TEFRA authority to eliminate the prior hospitalization requirement.

Explanation of provision.—The bill would make a number of changes in the scope of Medicare Part A benefits for those volun-

tarily enrolling in the Part B program. For those not electing Part B coverage, current law Part A provisions relating to coverage of hospital and skilled nursing facility benefits would continue to apply.

For beneficiaries voluntarily enrolling in the Part B program, the bill would eliminate the spell of illness concept and provide for unlimited hospital days and up to 150 days of SNF services during a calendar year. Further, the bill would repeal the inpatient psychiatric carryover restriction for those beneficiaries voluntarily enrolling in Part B. In addition, the bill would eliminate the prior hospitalization requirement to receive extended care services for beneficiaries enrolling in Part B.

Effective date.—Applies to items and services furnished after December 31, 1987, except that in the case of beneficiaries receiving SNF services on December 31, 1987, the changes would not apply until the individual's spell of illness had ended.

Section 3. Deductibles and Coinsurance Under Part A

Current Law.—Under current law, beneficiaries are liable for specified deductibles and coinsurance charges in connection with their use of inpatient hospital services and skilled nursing facility services. During each spell of illness, beneficiaries are required to pay an inpatient hospital deductible ($520 in 1987). A daily copayment equal to ¼th of the hospital deductible ($130 in 1987) is required for the 61st through 90th day. Lifetime reserve days are subject to a daily copyament charge equal to ½ of the inpatient hospital deductible ($260 in 1987). Beneficiaries using skilled nursing facility services are required to pay a daily coinsurance charge equal to ⅛ of the inpatient hospital deductible ($65 in 1987) for the 21st through 100th days.

Under current law a beneficiary is also required to pay a separate deductible equal to the first three pints of whole blood (or equivalent quantities of red blood cells) received by the beneficiary during each spell of illness.

Explanation of provision.—The bill would make a number of changes in the requisite deductible and coinsurance charges for inpatient hospital and skilled nursing facility services for persons voluntarily enrolling in the Part B program. These changes would be made in conjunction with the changes in the scope of Part A benefits authorized under Section 2 of the bill. For persons not voluntarily enrolling in Part B, the current law Part A deductible and coinsurance charges would continue to apply.

For beneficiaries voluntarily enrolling in the Part B program, one inpatient hospital deductible would be required for the first period of continuous hospitalization that begins in a calendar year. Beneficiaries who pay a deductible for an admission in December of a calendar year would not be required to pay an additional hospital deductible for a period of hospitalization beginning in January of the following year. The law would be further modified to provide that the blood deductible would apply to the first three pints of whole blood furnished each year rather than during each spell of illness.

For beneficiaries voluntarily enrolling the Part B program, the current SNF coinsurance requirements would be modified. These beneficiaries would be required to pay coinsurance for the first 10 days of covered SNF services, not to exceed 10 days in a year. The coinsurance amount for each day would be equal to 15 percent of the national average per diem reasonable cost recognized under Medicare for extended care services. The Secretary would be required in September of each year (beginning with 1987) to promulgate the coinsurance amount that shall apply to SNF services in the following year. This is estimated to be $18 in 1988.

Effective date.—Applies to items and services furnished after December 31, 1987, with the following exceptions. Beneficiaries whose spell of illness begins before January 1, 1988 and whose period of hospitalization included in that spell of illness begins on or after January 1, 1988 and before February 1, 1988 would not have an inpatient hospital deductible imposed for that period of hospitalization. Further, in the case of beneficiaries receiving SNF services on December 31, 1987, the changes would not apply until the individual's spell of illness had ended.

Section 4. Limitation on Cost-Sharing

Current law.—Under current law, beneficiaries are liable for specific deductible and coinsurance charges in connection with their use of inpatient hospital, skilled nursing facility, and hospice services and blood under Part A.

Beneficiaries voluntarily enrolling in Part B are required to pay a monthly premium. The Part B program generally pays 80 percent of the reasonable charge for physicians and other medical services (including immunosuppressive drugs furnished within one year of an organ transplant) after the beneficiary has met a $75 deductible. The beneficiary is liable for the remaining 20 percent known as coinsurance. In addition, where a physician does not accept assignment (i.e., does not agree to accept Medicare's determination of reasonable charge as payment in full for covered services), the beneficiary is liable for the difference between Medicare's reasonable charge amount and the physician's actual charge. This is sometimes referred to as the "balance billed" amount. A beneficiary is also required to pay a separate Part B blood deductible equal to the first three pints of whole blood received in connection with Part B services during a calendar year. (This is in addition to any blood deductible required to be paid under Part A in connection with inpatient services.) The law contains no upper limit on the amount of cost-sharing charges beneficiaries are required to pay in connection with covered Medicare services.

Explanation of provision.—The bill would establish an upper limit on beneficiary cost-sharing charges in connection with covered Medicare services. Only beneficiaries enrolled in Part B would be eligible for this limit. The catastrophic limit would be set at $1,700 in 1988. For succeeding years, the limit would equal the limit for the preceding year, increased by the cost-of-living adjustment (COLA) to Social Security benefits. The Secretary would be required to promulgate the Medicare catastrophic limit for a year by November 15 of the preceding year.

The bill would specify certain beneficiary expenses which would count toward the catastrophic limit. These are: the inpatient hospital deductible, skilled nursing facility coinsurance charges, hospice coinsurance charges, Parts A and B blood deductibles, and the Part B deductible and coinsurance amounts. Additionally, beneficiary expenses for immunosuppressive drugs furnished after the first year following an organ transplant would count toward the limit; countable expenses could not exceed reasonable charges. Beneficiary payments for balance billed amounts would not count toward the catastrophic limit.

The bill would also count toward the catastrophic limit certain expenses made by beneficiaries for specified routine examinations though these services are not covered services under the Medicare program. Specifically countable toward the catastrophic cap would be reasonable charges for: a) one routine mammography examination every three years for female Medicare beneficiaries aged 55 or older; and b) colorectal examinations each year for Medicare beneficiaries aged 65 or older. The Committee expects that the colorectal examination would include:

(1) One digital rectal examination per year when not provided as part of a routine physical examination, i.e., when provided as part of a general physical exam these examinations should not be billed separately.

(2) One office guaiac test and up to 3 mail guaiac tests per year.

(3) One sigmoidoscopy for those with a physical indication or a family or individual medical history of colorectal cancer.

The Committee expects the Secretary to establish and apply appropriate utilization guidelines for each of these tests. The Committee notes that the American Cancer Society recommends a sigmoidoscopy only every three to five years following two annual exams with negative results.

The bill would provide that after a beneficiary had incurred out-of-pocket expenses in a calendar year equal to the catastrophic limit, Medicare would pay 100% of the requisite cost-sharing amounts for: inpatient hospital services, extended care services, hospice services, Parts A and B blood supplies, and covered Part B services.

The bill would require the Secretary to provide for an appropriate adjustment in Medicare payment amounts to prepaid health care organizations paid on the basis of reasonable cost and to renal dialysis facilities. The adjustment is to reflect the increase in payments to such organization as if payments were made on an individual by individual basis. Such organizations and facilities would be required to assure the Secretary that they would not charge individuals eligible for Medicare catastrophic coverage for covered services after the individual had reached the catastrophic limit. The purpose of this requirement is to prevent the organization from receiving duplicate payments. The organization may accomplish this in an actuarial manner rather than by tracking each individual's expenditures and adjusting his payments to the organization after he has reached the cap. (See section 10 for provisions relating to risk-based prepaid health care organizations).

The bill would specify that institutional providers with agreements with the Medicare program would be prohibited from charging Medicare beneficiaries for services for which catastrophic benefit payments are made to the provider. No comparable limitation would apply with respect to balance billing charges by physicians.

Effective date.—Applies to items and services furnished after December 31, 1987. In 1988 only, only those expenses incurred on or after July 1, 1988 could count toward the catastrophic limit.

Section 5. Increase in Part B Premium

Current law.—Under current law, the Secretary is required to calculate and announce each September the amount of the monthly premium that will be charged in the following calendar year for Part B enrollees. Premium incomes were originally intended to finance half the costs of the Part B program. However beginning in 1973, the annual percentage increase could not exceed the annual cost-of-living adjustment (COLA) in social security cash payments. As a result, the percentage paid through beneficiary premiums declined to less than 25 percent of the total. The remaining portion is paid by Federal general revenues.

A temporary provision of law requires for calendar years 1984–1988 that the premium amount be calculated so as to produce premium income equal to 25 percent of program costs for the aged. If the premium increase is greater than the social security COLA, the premium increase is to be reduced so as to avoid a reduction in the individual's social security check. Beginning January 1, 1989, the premium calculation reverts to the method under which the annual increase may not exceed the COLA.

Explanation of provision.—The bill would provide for the financing of catastrophic benefits through a combination of an increase in the Part B premium and an income-related supplemental premium. The increase in the Part B premium would be paid by all beneficiaries enrolled in the Part B program.

The bill would provide for the calculation of a catastrophic coverage premium amount which would be added to the basic Part B premium amount. The catastrophic coverage premium amount would be $4 in 1988. The monthly catastrophic coverage premium amount for succeeding calendar years would be the amount for the preceding year increased (or decreased) by the percentage increase (or decrease) in the per capita actuarial costs of catastrophic benefits (and associated administrative costs). The indexing rate for 1989 and 1990 would be increased slightly both to account for the timing difference between implementation of the indexed premium and the actual collection of the premium and to insure the actuarial soundness of the premium. The Committee bill would provide that the catastrophic coverage premium amount would be appropriately reduced for persons covered under Part B but not Part A.

The catastrophic coverage premium amount would be added to the basic Part B premium amount. Current law requirements relating to the calculation of the basic Part B premium amounts would remain unchanged. Thus, beginning in 1989, the annual percentage increase in the basic premium amount could not exceed the social security COLA. The bill would provide that beginning January 1,

1989, if the catastrophic premium increase for an individual is greater than the dollar amount of the social security increase for that individual, the premium increase would be reduced so as to avoid a reduction in social security benefits.

The bill would also provide for periodic transfers from the Supplementary Medical Insurance Trust Fund to the Federal Hospital Insurance Trust Fund to account for expansions in Part A benefits for Part B enrollees.

Effective date.—Applies to premiums for months beginning after December 31, 1987.

Section 6. Supplemental Premium for Catastrophic Illness Coverage

Current law.—Under current law, all individuals who are age 65 or older may elect to enroll in the Medicare supplemental medical insurance program (Part B) by paying the monthly premium. Individuals who have not attained age 65 but who are eligible for the Medicare hospital insurance program (Part A) by virtue of disability or end-stage renal disease may also elect to enroll in Part B by paying the monthly premium. The monthly premium in 1987 is $17.90.

Explanation of Provisions

In general.—In general, under the bill, an individual who receives Medicare Part B coverage for any portion of a taxable year and who has Federal income tax liability greater than or equal to $150 for such year, is required to pay a supplemental premium based on the individual's Federal income tax liability for that year. For purposes of the Internal Revenue Code, this premium generally is to be treated in the same manner as an addition to income tax and thus is to be paid and collected in the same manner as an income tax. However, this premium is treated as a medical expense for purposes of section 213 of the Code (which allows a deduction for medical expenses in excess of 7.5 percent of adjusted gross income (AGI)) in the taxable year following the taxable year to which the premium relates.

Amount of the supplemental premium.—Under the bill, the amount of the applicable supplemental premium imposed on any individual is determined as follows. The applicable supplemental premium equals the monthly supplemental premium multiplied by the number of months in a taxable year in which the individual received Medicare Part B coverage. The monthly supplemental premium, in turn, equals the "premium rate" for the taxable year multiplied by a specified amount that depends on the individual's tax liability.

The premium rate used to determine the monthly supplemental premium is $1.02 for any taxable year beginning before 1989. The specified amount that is multiplied by the premium rate to determine the monthly supplemental premium is calculated by dividing the individual's Federal income tax liability for the taxable year by $150 and then rounding the result to the next lowest number. Thus, for example, if an individual has less than $150 of Federal

income tax liability, the specified amount for such individual is zero.

For purposes of this determination, the term "Federal income tax liability" means the tax imposed by Chapter 1 of the Code (without regard to this provision) reduced by the amount of the earned income credit and the amount of nonrefundable credits allowed under Part IV of Subchapter A of Chapter 1.

The $1.02 premium rate is to be adjusted for taxable years beginning after 1988 in accordance with the percentage increase or decrease in the per enrollee actuarial comprehensive catastrophic benefit amount (within the meaning of sec. 1839(g)(2)(C)(ii) of the Social Security Act as added by the bill) for the calendar year in which the taxable year begins as compared to the preceding calendar year. An appropriate adjustment applies to taxable years beginning in 1989. In addition, the Secretary is directed to adjust the otherwise applicable premium rate for any taxable year beginning in a calendar year after 1992 to prevent inappropriate increases or decreases in the applicable supplemental premium attributable to certain changes in the average Federal income tax liability of individuals required to pay the supplemental premium.

For years beginning after 1992, the Secretary is further directed to increase the premium rate and the monthly catastrophic coverage premium (in proportional amounts) to the extent necessary so that the estimated total catastrophic coverage revenues collectable for liabilities arising in such year equals the total catastrophic coverage benefits (within the meaning of section 1839(g)(2)(C)(i)) and related administrative costs incurred in such year.

The applicable supplemental premium for any individual in a taxable year is subject to a limit. For taxable years beginning after 1987 and before 1993, the limit is the amount specified below multiplied by a fraction the numerator of which is the number of months in the taxable year in which the individual received Part B coverage, and the denominator of which is 12. The amount to be multiplied by this fraction is:

If the taxable year begins in:	The amount is:
1988	$800
1989	850
1990	900
1991	950
1992	1,000

In the case of a taxable year beginning after 1992, the limit is 65 percent of, in effect, the excess of the value of the basic Part B coverage and the catastrophic coverage over the premiums charged for such coverage (other than the applicable supplemental premium). For this purpose, the premiums are to be determined without regard to section 1839(f)(2) or 1839(g)(3) of the Social Security Act (prohibiting an increase in such premiums with respect to an individual to the extent that such increase would reduce the net social security benefit payable to such individual).

Treatment of joint returns.—In general, if a married couple files a joint return, the applicable supplemental premium is to be determined as if the husband and wife were one individual. Thus, the joint Federal income tax liability is used to determine the monthly supplemental premium applicable to the couple. The monthly sup-

plemental premium, as so determined, is then multiplied by the number of months in the taxable year in which the "individual" received Part B coverage. For this purpose, the individual is the spouse with the higher number of months (or if the number of months is the same for both spouses, either spouse).

The limitation on the applicable supplemental premium for a married couple filing a joint return (if both spouses received Part B coverage during the year) is the sum of the limits that would apply to each spouse if determined separately under the general rule.

Collection of the supplemental premium.—In general, for purposes of the Code, the applicable supplemental premium is to be treated in the same manner as an addition to income tax and thus is to be paid and collected in the same manner as an income tax. However, for purposes of determining (1) the amount of credits allowable under Chapter 1 of the Code, and (2) the amount of the minimum tax imposed by section 55 of the Code, the applicable supplemental premium is not to be considered an addition to income tax.

Notwithstanding the general treatment of the applicable supplemental premium as an addition to income tax, it is treated as a medical expense for purposes of section 213 (which allows a deduction for medical expenses in excess of 7.5 percent of AGI) in the taxable year following the taxable year to which the premium relates.

Transfers to the Part B Trust Fund.—The Secretary of the Treasury shall, from time to time, transfer from the general fund of the Treasury to the Federal Supplementary Medical Insurance Trust Fund amounts equal to the aggregate applicable supplemental premiums paid plus the net savings to the Federal Government under the Medicaid program attributable to this bill. This transfer is to be appropriately adjusted to the extent that prior transfers were in excess of or less than the correct amount.

Information reporting.—The bill requires that the Secretary of Health and Human Services make an information return stating (1) the name and address of each individual covered by Medicare Part B at any time during the calendar year, and (2) the number of months such individual is so covered.

Effective date.—The applicable supplemental premium provision of the bill is effective for taxable years ending after December 31, 1987.

Section 7. Medicare Coverage of Home Health Services on a Daily Basis

Current law.—Under current law home health services are covered under Medicare if the services are required because the individual is homebound and requires skilled nursing care on an intermittent basis or physical or speech therapy. Current program guidelines specify that to meet the requirement for intermittent skilled nursing care, an individual must have medically predictable recurring need for skilled nursing services. The guidelines define "intermittent" as permitting daily skilled nursing visits for up to eight hours a day for up to two or three weeks if medically reason-

able and necessary. Daily is defined as five, six, or seven days per week.

Explanation of provision.—The bill would clarify that daily is defined as seven days a week with one or more visits per day. Such care may be provided for a period of up to 21 days with a physician's certification of the need for such care and services on a daily basis.

The bill would extend the number of days for which beneficiaries enrolled in Part B could receive daily home health benefits. For these beneficiaries, 45 days of daily care would be allowed if the beneficiary were discharged from either a hospital or skilled nursing facility within 30 days prior to beginning home health care.

Effective date.—Applies to services furnished after December 31, 1987.

Section 8. Clarification of Requirement That Individual Be Confined to Home To Be Eligible for Home Health Services

Current law.—Under current law, an individual must be confined to his or her home in order to receive home health services. This is known as the homebound requirement.

Explanation of provision.—The bill would clarify the definition of homebound. It would specify that an individual shall be considered to be confined to his home if: (a) the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the aid of a supporting device (such as crutches, a cane, a wheelchair, or a walker); or (b) the individual has a condition such that leaving his or her home is medically contraindicated. The bill would provide that an individual does not actually have to be bedridden to be considered homebound. However, the individual's condition should be such that there exists a normal inability to leave home, that leaving home would require a considerable and taxing effort, and that absences from the home are infrequent or of relatively short duration.

Effective date.—Applies to services furnished after December 31, 1987.

Section 9. Annual Notice to Medicare Beneficiaries

Current law.—Under existing law, there is no requirement for an annual notice to Medicare beneficiaries about the scope of benefits available to them under the Medicare program. Information on Medicare coverage is generally available through Social Security Administration district offices.

Explanation of provision.—The bill would require the Secretary to notify annually each Medicare beneficiary of the benefits available and categories of health care not covered under Medicare, Medicare payment limitations (including deductibles and coinsurance), and the way payment limitations for beneficiaries covered by Part B differ from those for beneficiaries not covered by Part B. The bill requires that such notice also be provided when an individual applies for benefits under Part A or enrolls in Part B, and annually thereafter. It requires that the notice be prepared in consultation with groups representing the elderly and with health insurers.

Effective date.—The requirement to provide notices to new beneficiaries is effective January 1, 1988. The notice to all beneficiaries applies to annual notices beginning for 1988.

Section 10. Adjustment of AAPCC's and Contracts for Risk-Based Organizations

Current law.—Section 1876 of the Social Security Act, as amended by the Tax Equity and Fiscal Responsibility Act of 1982, provides for Medicare payments to Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) on either a risk or a cost contracting basis. In general, risk contracting plans are financially responsible for the cost of all benefits their enrollees would otherwise be eligible for under Medicare. Reimbursement of HMOs and CMPs is determined based on estimates of the average adjusted per capita cost (AAPCC) and the adjusted community rate (ACR).

Explanation of provision.—The bill requires the Secretary to modify for eligible risk-based organizations (under Section 1876 of the Social Security Act) the adjusted average per capita cost (AAPCC) to reflect the catastrophic coverage provided in this bill. It requires the Secretary to modify each contract for portions of contract years occurring after December 31, 1987 to reflect the changes made in the AAPCC. In addition, each risk-based organization is required to make appropriate adjustments in terms of its agreements with Medicare beneficiaries to take into account the catastrophic coverage provided under the bill.

Effective date.—Enactment.

Section 11. Study of Treatment of Prescription Drugs

Current law.—Under current law, Medicare generally pays for prescription drugs only when they cannot be self-administered, are furnished as an incident to a physician's service, and are included in the physician's bill. Drugs furnished as part of inpatient services are included within the payment to the provider. Immunosuppressive drugs furnished to a beneficiary who receives an organ transplant are covered for one year after the date of the transplant as a Part B service, subject to the Part B deductible and coinsurance requirements. Limited drug payments are also included as part of the hospice benefit.

Explanation of provision.—The bill requires the Secretary to request the National Academy of Sciences, acting through the Institute of Medicine, to study and report on additional drugs, available by prescription only, that might be covered under Medicare, or counted toward the catastrophic limit. The study is to include analyses and recommendations with respect to appropriate payment limits. The Institute of Medicine is required to provide an interim report on the study to Congress within 6 months of the bill's enactment and a final report, including specific findings and recommendations, within 12 months of enactment.

Effective date.—Enactment.

Section 12. Hospice Care

Current law.—Under current law, a beneficiary who is terminally ill may elect to receive hospice services for two 90 day periods and one subsequent 30 day period for a total of 210 days during his lifetime. Beneficiaries making this election must choose to receive services through a hospice and give up most other Medicare benefits. At the expiration of 210 days of covered hospice care, the patient's revocation of other Medicare benefits ends. A patient may continue to use hospice services. In this case the patient will be charged, to the extent he or she can afford to pay, for hospice services not otherwise covered by Medicare.

Explanation of provision.—The bill would eliminate the maximum 210 day limit on hospice coverage for all Medicare beneficiaries. A Medicare beneficiary would be entitled to an indefinite subsequent extension period if the medical director or attending physician recertifies at the beginning of such period that the individual is terminally ill.

Effective date.—Enactment.

Section 13. Voluntary Certification of Medicare Supplemental Health Insurance Policies

(a) Establishment of new model standards

Current law.—Under section 1882 of the Social Security Act (commonly referred to as the Baucus amendment), insurers who market private insurance policies to fill the gaps in Medicare may have the policies certified by the Secretary of Health and Human Services if the policies meet minimum standards. These standards are contained in a model state program approved by the National Association of Insurance Commissioners (NAIC) on June 1, 1979, and are incorporated by reference in section 1882 of the Social Security Act. Policies that are certified by the Secretary may be marketed as Medigap policies. However, if a State has adopted laws and/or regulations at least as stringent as those of the NAIC, policies regulated by the State are deemed to meet Federal requirements. Currently 46 States, the District of Columbia, and Puerto Rico meet these requirements.

The model standards require Medigap policies to: (1) cover all of the Medicare Part A inpatient coinsurance for the 61st through 90th day in the hospital, and the 60 lifetime reserve days, plus 90 percent of covered hospital inpatient expenses for a lifetime maximum of up to 365 days after the insured has exhausted Medicare benefits; (2) cover 20 percent of the amount of Medicare eligible expenses under Part B, subject to a calendar maximum out-of-pocket deductible of $200 and a maximum benefit of at least $5000 in a given calendar year; (3) not contain waivers to exclude, limit or reduce coverage or benefits for more than 6 months for pre-existing diseases or physical conditions that were diagnosed or treated within 6 months before the effective date of the coverage; (4) automatically change as Medicare's deductibles and coinsurance requirements are changed; (5) have a "free look" period, during which an individual may return an unwanted policy for cancellation and receive a full refund on any premium paid; (6) provide

cancellation and termination clauses to be prominently displayed; and (7) at the time of sale, provide an outline of coverage for a Medicare supplement policy.

The Baucus amendment also provides for loss ratio targets for Medigap policies that set a goal for the percentage of insurance premiums to be returned to policyholders in the form of benefits. Medigap policies must be expected to pay benefits at least equal to 60 percent of the earned premiums for individual policies and 75 percent for group policies.

Under the Baucus amendment, there are federal sanctions, consisting of fines and/or imprisonment, for: (1) furnishing false information to obtain the Secretary's certification, (2) posing as a federal agent to sell Medigap policies, (3) knowingly selling policies that duplicate coverage the individual already has, and (4) selling supplemental policies by mail in states that have not approved, or are deemed not to have approved, their sale.

It has been argued that Medigap or private supplemental insurance policies are already meeting the catastrophic medical needs of the elderly. About seventy percent of the elderly buy Medigap insurance. However, according to a recent study by the General Accounting Office (GAO/HRD-87-8), many of these policies are inefficient Medicare supplements. On average, commercial policies return only 60 cents on the dollar in benefits. The remaining 40 cents represents administrative and marketing costs and profits. GAO computed that a majority of the commercial Medigap policies (64 percent) fell below the loss ratio targets established under the Baucus amendment. However, the 34 percent of policies that were above the targets were for those policies most frequently purchased. For individual commercial policies, GAO found that Medicare beneficiaries were receiving 60 cents in benefits for every $1 in premiums. For the Blue Cross/Blue Shield individual policies, the return was 81 cents in benefits for every $1 in premiums. Some policies had low loss ratios because of waiting periods for certain conditions when the policy would not cover services.

Approximately 2 percent of Medicare spending is for administrative costs, which means that the remaining 98 percent is spent for benefits. The Medicare program also does not deny benefits for preexisting conditions.

The likelihood of a Medicare beneficiary having a Medigap policy increases with family income. In 1984, 44 percent of those with incomes under $5,000 were covered, compared with 87 percent of those with incomes of $25,000 or more. Low-income elderly, therefore, are often without the supplemental policies that could help them to meet the costs of catastrophic illnesses.

Explanation of provision.—The bill provides that if the National Association of Insurance Commissioners revises the existing standards for Medigap policies within 90 days after enactment, then those standards will apply as the standard for certification, beginning one year later. If the National Association of Insurance Commissioners does not revise the standards within 90 days, the bill requires the Secretary to issue Federal model standards within 90 days, to become effective one year later.

Effective date.—Enactment.

(b) Free look period

Current law.—Under the existing NAIC standards, Medigap policies are required to provide a "free look" period of 10 days for policies sold by agents and 30 days for policies sold by mail, during which a policyholder may return the policy and get a full refund of any premium paid.

Explanation of provision.—Section 1882 is amended to require a uniform 30-day free look period for all Medigap policies, whether sold by agents or by mail.

Effective date.—Applies to policies sold once the new model standards are implemented.

(c) Loss ratios

Current law.—Section 1882 requires that Medigap policies must be expected to pay benefits at least equal to 60 percent of the earned premiums for individual policies and 75 percent for group policies. Policies issued as a result of solicitations through the mails or by mass media advertising are considered individual policies.

HHS has interpreted the requirement for expected loss ratios as not requiring state regulators to monitor the actual loss ratios of Medigap policies.

Explanation of provision.—The law would be amended to require states which have approved certification programs to adopt reporting forms developed by the National Association of Insurance Commissioners in order to collect information on actual loss ratios.

The Committee intends that, under this new requirement, the NAIC would review the feasibility and appropriateness of alternatives for informing consumers about Medigap standards including adding to the model standards an additional requirement that each Medigap policy have printed on it the loss ratio for that policy.

Effective date.—Applies to policies sold once the new model standards are implemented.

(d) Consumer information

Current law.—Section 1882 requires that the Secretary provide to individual Medicare beneficiaries information that will permit them to assess the value of the Medicare supplement policies to them and the relationship of any such policies to benefits under the Medicare program.

Explanation of provision.—The bill would amend Section 1882 to require the Secretary of Health and Human Services to (i) inform Medicare beneficiaries about current laws that prohibit certain marketing and sales abuses, (ii) establish a toll-free number for beneficiaries to report prohibited practices to the Inspector General, and (iii) inform Medicare beneficiaries of the addresses and telephone numbers of appropriate State and Federal offices where information and assistance relating to private insurance coverage and Medicare benefits may be obtained.

Effective date.—Enactment.

Section 14. Determination of Medicaid Savings; State Plan Requirements

Current law.—An estimated 2.4 million aged and disabled Medicare enrollees are also covered by State Medicaid programs. All State Medicaid plans, except for Wyoming, pay the monthly Part B premium for dual enrollees under a "buy-in" agreement. While States may "buy-in" to Part B for both their cash and noncash assistance populations, Federal matching for premium payments is available only for the cash assistance group. If a State does not buy-in for Part B coverage, it cannot receive Federal matching payments for medical services which would have been covered under Medicare if there were such an arrangement. Some States also pay some or all of the Medicare coinsurance and deductible amounts. Federal matching is available for these costs.

P.L. 99–509 created an optional categorically needy coverage group under Medicaid composed of elderly and disabled persons with incomes up to a State-established level that does not exceed 100 percent of the Federal poverty line. A State choosing this option would have to either offer the benefit package available to other categorically needy beneficiaries or alternatively cover just the Medicare cost-sharing charges. A State electing either option would also be required to cover some newly eligible pregnant women and children. The expanded coverage provision is effective July 1, 1987.

Explanation of provision.—Under the catastrophic coverage provisions of the bill, States would pay a reduced amount for those individuals for whom they currently pay the Medicare deductibles and coinsurance. The bill would require the Secretary, before the beginning of each fiscal year, to estimate the amount that each State Medicaid program would have spent from State funds under Medicaid in such year in the absence of the catastrophic coverage provisions. The Secretary would be required to notify States of this amount.

The bill would require each State Medicaid plan as a condition of approval, to spend an amount equal to its estimated savings on one or both of the following: (a) providing Medicaid coverage for Medicare-cost-sharing charges on behalf of newly eligible aged and disabled Medicare beneficiaries, pursuant to the provisions of P.L. 99–509; or (b) increasing the maintenance needs levels applicable under the plan for the community spouses of institutionalized individuals. The amounts expended under this requirement would have to be in addition to any amounts which would have been expanded for such purposes pursuant to the provisions of the State plan in effect prior to enactment of this Act. States electing, under this provision, to pay Medicare cost-sharing charges would be exempt from the OBRA requirement that a State must also cover newly eligible pregnant women and children.

Effective date.—The provision would be effective for 12 calendar quarters beginning January 1, 1988, except that delay would be permitted where State legislation is required. If the beginning date is later than January 1, 1988, the 12 calendar quarters begins on that later date.

Section 15. Studies of Long-Term Care

(a) Institute of Medicine study of long-term care

Current law.—Under current law, Medicare does not cover services required for individuals whose chronic conditions require long-term nursing home or home and community-based services.

Explanation of provision.—The bill would require the Secretary to request the National Academy of Sciences through The Institute of Medicine to study options for the private funding of a portion of long-term care, including Federal incentives to facilitate this funding, the effect of private funding on public funding of such care, options for public sector long-term care coverage, the effectiveness and cost of community-based long-term care services, and the sources of funding from individuals for each long-term care option. The bill requires the Institute of Medicine to report to the Secretary and to Congress by October 1, 1989 on the study, data obtained, and administrative action and changes in law appropriate to implement the study's findings.

Effective date.—Enactment.

(b) Department of Treasury study of tax incentives for long-term care

Current law.—There is no current requirement that the Secretary of Treasury conduct a study on the financing of long-term care. The President has asked the Department of Treasury to review tax policy as it affects the provision of catastrophic and long-term care health insurance.

Explanation of provision.—The bill would require the Secretary of the Treasury to conduct a study and make recommendations prior to April 1, 1988 with respect to tax policies to encourage the private financing of long-term care. The study would examine long-term care provided by nursing homes, home health programs, and other service delivery mechanisms. The Secretary would be required to seek the views of the insurance industry and of providers of long-term care.

Effective date.—Enactment.

Section 16. Case Management Demonstration Projects

Current law.—"Case management" is a system under which a designated person or organization has responsibility for overseeing health care services for individuals assigned to the person or organization. Where case management is used, an insurer usually will not pay (or will pay less) for those services that are provided without permission of the case manager.

Under current law, there are no requirements for Medicare beneficiaries to receive case management services and case management is not a covered service under the Medicare program. Utilization and quality control peer review organizations (PROs) are responsible for reviewing the necessity and quality of services for Medicare beneficiaries.

Explanation of provision.—The bill would require that the Department of Health and Human Services establish not less than six projects to demonstrate the feasibility of applying case management to Medicare beneficiaries with catastrophic illnesses. The sub-

stitution of lower-cost, medically appropriate services is desirable. Complicated long-stay cases should benefit from rigorous case management to hold down costs. Better coordination of services can be a substantial benefit to ensure that the most appropriate and cost effective services are identified and available to patients. Such coordination, in the form of case management, is a growing practice in the private sector and has been an optional service under the Medicaid program since April 1986. In view of the relative acceptance of case management and the benefits that it provides, the Committee believes that it would be useful to demonstrate the effectiveness of and methodology for case management for Medicare patients with selected catastrophic illnesses.

Under the demonstration project, PROs, using existing screening mechanisms, would identify cases that are at risk for becoming high cost or long stay and which might benefit from coordination of services, discharge follow-up and post-hospital support services. PROs or case managers under contract with PROs would provide the case management services. Nurse case reviewers would work with the physician and other providers to ensure the provision of medically necessary services. The nurse reviewer could disseminate information to patients and their physicians regarding the availability of various treatment alternatives and specialized care facilities.

The Committee recognizes that under current Medicare law beneficiaries are free to choose their own physician, hospital, and other providers. The Committee does not intend that the demonstrations will alter that freedom-of-choice.

The demonstration projects once established would provide case management services for one year, with total funding limited to $2 million, to be transferred directly from the Medicare Trust Funds.

At the end of the first six full months of experience, the demonstration PROs will report to the Secretary on the results of these 1 demonstrations. The Secretary will combine the results of these demonstrations with evaluations of other case management research under the Medicare program to report to the Congress on the need for introduction of case management under Medicare and the best approach to take in designing and implementing such a program.

Effective date.—The Secretary is required to have the demonstrations in place 12 months after enactment. The interim reports are due 6 months from the date on which the demonstrations are initiated.

Section 17. Repeal of Authority To Administer Proficiency Examinations

Current law.—Section 1123 of the Social Security Act allows the use of a testing program to determine the proficiency of individuals who desire to become skilled medical technicians. In the conduct of such tests, no individual who otherwise meets the proficiency requirements for the health care specialty can be denied a satisfactory proficiency rating solely because of his failure to meet formal educational or professional membership requirements. Currently, persons who are judged proficient as a result of this test may avoid

going through an accredited education program designed to train such personnel.

Explanation of provision.—Section 1123 would be repealed. The repeal of this provision would not effect the exam scheduled for August 1987, nor would it effect the status of individuals who were certified by reason of previously administered exams.

Effective date.—October 1, 1987.

Section 18. Trustee Comments on Actuarial Soundness of Basic and Supplemental Catastrophic Benefit Premiums

Current law.—Under current law, the Social Security Act requires that the Trustees of the Hospital Insurance and Supplementary Medical Insurance trust funds report to the Congress not later than April 1 of each year on the operation and status of the trust funds during the preceding fiscal year and on its expected operation and status during the current fiscal year and the next two fiscal years.

Explanation of provision.—The Committee's bill would require that the Trustees of the Medicare trust funds comment in their annual reports with respect to the actuarial soundness of the monthly catastrophic coverage premium and the supplemental premium to cover the cost of catastrophic benefits.

Effective date.—Effective for Trustees' annual reports beginning with those issued for 1988.

Section 19. Home and Community-Based Waiver Technical Change

Current law.—Under current law, the Secretary of HHS is authorized to waive certain Medicaid requirements to allow States to provide a broad range of home and community-based long-term care services. These services are for individuals who would otherwise require, and have paid for by Medicaid, the level of care provided in a hospital, skilled nursing facility, or intermediate care facility. Waivers to provide home and community-based services are frequently referred to as 2176 waivers after the section in the Omnibus Budget Reconciliation Act of 1981 which originally authorized them. Under the 2176 waiver program, the Secretary of HHS is allowed to waive two specific Medicaid requirements: (1) a requirement that Medicaid services be available throughout a State (known as statewideness) and (2) a requirement that covered services be equal in amount, duration, and scope for various groups eligible for Medicaid benefits in a State (known as comparability). By allowing the Secretary to waive these requirements, the enabling legislation intended to provide the States flexibility to offer selected 2176 home and community-based services in only a portion of the State, rather than in all geographic jurisdictions as would be required absent the waiver, and to offer selected services to certain State-defined individuals eligible for Medicaid assistance, rather than offering such services to all persons in particular groups. In addition, States have been able to extend to waiver participants the more liberal Medicaid income eligibility rules that may be applied to persons in institutions.

An amendment enacted in the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509) was intended to clarify the Secretary's authority to waive the comparability of services requirement for all recipients. Instead the provision deleted the ability of the Secretary to waive the income eligibility rules for medically needy recipients.

Explanation of provision.—The bill would restore the ability of the Secretary to extend to waiver participants the income eligibility rules that apply to persons in institutions.

Effective date.—Enactment.

Section 20. Technical Amendments Relating to New Jersey Respite Care Pilot Project

Current law.—Medicaid does not currently cover respite care services except where provided under a home and community-based services waiver approved by the Secertary under section 1915(c). However, section 9414 of the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509, also known as OBRA) established a respite care pilot project under the Medicaid program in New Jersey.

The Health Care Financing Administration has interpreted section 9414 to require a formal waiver. To implement the pilot project, the Committee believes that certain technical corrections to OBRA are necessary.

Explanation of provision.—Section 9414 of OBRA is modified to provide that (i) a description of the project is required rather than a formal waiver request; (ii) the State may use a post-eligibility cost sharing formula, based on available income; and (iii) eligible participants will be defined.

Effective date.—Enactment

III. HEARINGS

The Committee on Finance held hearings on catastrophic health insurance proposals on January 28, 1987, March 19, 1987, and March 26, 1987.

IV. COMMITTEE VOTE

The Committee on Finance considered S. 1127 on May 28 and May 29, 1987. On May 29, 1987, the Committee ordered the bill reported with an amendment by a rollcall vote of 20-0.

V. COSTS OF CARRYING OUT THE BILL

U.S. Congress,
Congressional Budget Office,
Washington, DC, July 2, 1987.

Hon. Lloyd Bentsen,
Chairman, Committee on Finance,
U.S. Senate, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the attached cost estimate for S. 1127, the Medicare Catastrophic Loss Prevention Act of 1987, as ordered reported on May 29, 1987, by the Committee on Finance.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,

Sincerely,

ROBERT F. HALE
(For Edward M. Gramlich, Acting Director).

Congressional Budget Office Cost Estimate

1. Bill number: S. 1127.

2. Bill title: The Medicare Catastrophic Loss Prevention Act of 1987.

3. Bill status: As ordered reported by the Committee on Finance on May 29, 1987.

4. Bill purpose: To amend title XVIII of the Social Security Act to provide protection against catastrophic medical expenses under the Medicare program, and for other purposes.

5. Estimated cost to the Federal Government:

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
DIRECT SPENDING/OFFSETTING RECEIPTS					
Hospital Inpatient Benefits:					
Eliminating the limit on covered hospital days:					
Budget authority	205	315	360	395	440
Outlays	180	300	345	380	420
Eliminating enrollees' copayments for hospital coinsurance and reserve days:					
Budget authority	330	510	580	640	710
Outlays	295	485	560	615	680
Limiting payment of the hospital deductible to the first stay each year:					
Budget authority	425	545	575	620	685
Outlays	395	530	550	595	655
Year end protection on deductible payments:					
Budget authority	0	9	10	11	12
Outlays	0	9	10	11	12
Changing blood deductible requirements from 3 per spell to 3 a year:					
Budget authority	6	8	10	10	11
Outlays	5	8	10	10	11
Skilled Nursing Facility Benefits:					
Changing the requirements for coinsurance on SNF stays, and covering up to 150 days a year:					
Budget authority	195	300	340	375	410
Outlays	175	285	325	360	395
Eliminating the prior hospitalization requirement for coverage of SNF stays:					
Budget authority	40	50	60	70	80
Outlays	35	50	55	65	75
Home Health Benefits:					
Extending home health benefits to 21 consecutive days:					
Budget authority	4	5	5	5	5
Outlays	4	5	5	5	5
Extending home health benefits to 45 consecutive days for enrollees with an inpatient or SNF discharge in the preceding 30 days:					
Budget authority	125	185	215	245	280
Outlays	115	175	205	235	270

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Hospice Benefits:					
Eliminating the 210 days limit on hospice benefits:					
Budget authority	(1)	1	1	1	1
Outlays	(1)	1	1	1	1
Copayment Cap:					
Capping copayments under Parts A and B combined:					
Budget authority	400	1,805	2,845	3,525	4,240
Outlays	176	1,622	2,704	3,368	4,056
Counting costs of immunosuppressive drugs toward the cap:					
Budget authority	5	20	25	30	45
Outlays	5	20	25	30	40
Counting costs of certain screening exams toward the cap:					
Budget authority	(1)	20	30	40	45
Outlays	(1)	20	30	40	45
Part B Premiums:					
Increasing flat premium:					
Budget authority	−760	−1,685	−1,945	−2,285	−2,655
Outlays	−760	−1,685	−1,945	−2,285	−2,655
Imposing an income-related supplemental premium: 2					
Budget authority	−660	−2,300	−2,660	−3,135	−3,620
Outlays	−660	−2,300	−2,660	−3,135	−3,620
Medicaid Savings:					
Effects of Medicare provisions on federal Medicaid costs:					
Budget authority	−75	−205	−300	−360	−420
Outlays	−75	−205	−300	−360	−420
Medicaid Benefits:					
Requiring state Medicaid programs to use savings to expand benefits:					
Budget authority	10	145	290	295	65
Outlays	10	145	290	295	65
Total, Direct Spending/Offsetting Receipts:					
Budget authority	250	−272	441	482	334
Outlays	−100	−535	210	230	35
AMOUNTS SUBJECT TO APPROPRIATIONS					
Administrative costs to implement copayment cap: Outlays	60	20	20	20	20
Annual notice to enrollees of benefits under Medicare: Outlays	4	4	4	4	4
Prescription drug study: Outlays	1	0	0	0	0
Long-term care study: Outlays	2	0	0	0	0
Case management demonstration: Outlays	2	0	0	0	0
Total, Amounts Subject to Appropriations: Outlays	69	24	24	24	24
Total:					
Budget authority	160	−177	441	482	334
Outlays	−31	−511	234	254	59

1 Less than $0.5 million.
2 Estimates are from the Joint Committee on Taxation.

Note: Components may not sum to total due to rounding.

The effects of this bill fall within function 570 and function 550.

BASIS OF ESTIMATE

Under current law, Part A of Medicare (Hospital Insurance) pays most of the costs for Medicare-covered services provided by hospitals, skilled nursing facilities (SNFs), home health agencies, and hospices. Enrollees share the costs of services through a variety of copayment requirements, most of which are related to the first-day hospital deductible amount (which was $520 in 1987). Part B of

Medicare (Supplementary Medical Insurance) pays for services provided by physicians, independent laboratories, and hospital outpatient departments. Under current law, SMI enrollees are responsible for the first $75 of covered medical expenses, plus 20 percent of all reasonable charges above the deductible amount.

The bill would change Medicare's copayment requirements and provide some expansion of coverage for Part B enrollees only, with the result that Medicare's reimbursement costs would increase. Over the five-year projection period, the additional Medicare benefits provided under this bill would be financed by increases in the SMI premium and by implementation of a new income-related premium collected through the income tax system. There would also be some expansion of benefits under Medicaid, financed by the Medicaid savings that the new Medicare benefits would generate.

Estimates of the costs to Medicare from the copayment provisions of this bill were derived by simulating the effects of proposed changes on a 1 percent random sample of Medicare enrollees (about 300,000 enrollee records). Medicare reimbursement and copayment costs for these enrollees in 1985 under current law were aged to 1988 through 1992, using CBO's baseline projections for enrollment and reimbursements, separately for each major service category. Total Medicare reimbursements under current law were compared to what reimbursements would be after implementation of the proposed provisions to obtain the estimated costs of the benefit expansion.

Under current law, Medicare reimbursements per enrollee are projected to increase by about 9.6 percent annually between 1987 and 1992. Under this bill, reimbursements per enrollee would increase by an estimated 10.6 percent annually over the same period. About 90 percent of the additional benefit costs would be due to the assumption by Medicare of some enrollees' copayment liabilities for current services. The remaining 10 percent of estimated costs would be due to increased use of Medicare-covered services by enrollees. The utilization responses assumed in the estimate were based on regression analyses of health care use by Medicare enrollees with and without supplementary insurance coverage for their Medicare copayment costs, using 1984 Health Insurance Survey data.

The revenue estimates for the income-related premiums were obtained from the Joint Committee on Taxation, and were based on simulations on a stratified random sample of current income tax returns, projected through 1992.

The specific provisions of the bill are explained in detail below. Unless otherwise indicated, the provisions would take effect on January 1, 1988.

DIRECT SPENDING/OFFSETTING RECEIPTS

Hospital Inpatient Benefits

The estimates in this section take account of Medicare's additional reimbursements to hospitals to compensate for Medicare enrollees' bad debt—that is, the failure by some enrollees to pay the deductible and coinsurance amounts for which they are liable. Estimates by the Inspector General of the Department of Health and

Human Services indicate that about 4 percent of enrollees' copayment liabilities for hospital stays are bad debt, which is eventually paid by Medicare.

Eliminating the limit on covered hospital days.—Under current law, Medicare will cover up to 90 days during each spell of illness, plus an additional lifetime reserve of up to 60 days. In addition, there is a lifetime reserve of 190 days for inpatient psychiatric care. This bill would eliminate the limit on covered hospital days for general care, but would retain the lifetime limit for inpatient psychiatric care.

Only a fraction of a percent of enrollees (fewer than 0.1 percent) exhaust their hospital benefits for general inpatient care each year, but the costs such patients incur are substantial. Covering these days would cost Medicare $180 million in fiscal year 1988. This estimate is based on information provided by the Health Care Financing Administration, indicating that this provision would add about 0.5 percent to total inpatient costs for Medicare-covered inpatient stays.

Eliminating enrollees' copayments for hospital coinsurance and reserve days.—Under current law, enrollees pay one-forth of the first-day hospital deductible amount for days 61–90 in a given spell of illness (coinsurance days), and one-half of the deductible amount for any lifetime reserve days used. This bill would eliminate enrollees' liability for coinsurance and reserve days. About 0.5 percent of HI enrollees use coinsurance or reserve days each year, accounting for an estimated 2.3 million coinsurance days and 0.7 million reserve days in 1988. Eliminating these inpatient coinsurance costs would cost Medicare $295 million in fiscal year 1988.

Limiting payment of the hospital deductible to the first stay each calendar year.—Under current law, enrollees are liable for a hospital deductible each time they are admitted to the hospital for a new spell of illness (which begins on the 61st day following discharge from a previous inpatient episode). In 1988, about 800,000 enrollees will pay more than one first-day deductible under current law, while no one would be liable for more than one deductible each year under this bill. In addition, the bill contains a hold-harmless provision that would protect enrollees who were readmitted after January 1, 1988, within a spell of illness that had begun prior to that date from paying another deductible for such admissions. These provisions would cost Medicare an estimated $395 million in fiscal year 1988.

Year-end protection on deductible payments.—Enrollees would be protected from having to pay a hospital deductible for admissions both in December of one year and in January of the following year. For enrollees with such an admission experience, the deductible for the January admission would be waived. Month-by-month tabulations of hospital admissions during calendar year 1985 indicate that about 0.2 percent of all enrollees with any hospital stays during the year would benefit from this provision. This would represent about 15,000 enrollees in 1989, the first year this protection would be meaningful, and would cost about $9 million in fiscal year 1989.

Changing blood deductible requirements.—Under current law, enrollees are required to replace or pay for the first 3 pints of blood

used each spell of illness. This bill would require enrollees to replace or pay for the first 3 pints of blood used each year. Medicare costs would increase under this provision because enrollees would pay for an estimated 156,000 fewer pints of blood used in 1988 than they would under current law, costing Medicare about $50 per pint. The additional costs to Medicare in fiscal year 1988 would be about $5 million.

Skilled Nursing Facility Benefits

These provisions relate to Medicare coverage of stays in skilled nursing facilities (SNFs). They would change coinsurance requirements, provide for coverage of up to 150 days a year, and eliminate the 3-day prior hospitalization requirement for covered SNF care.

Changing the requirements for coinsurance on SNF stays, and covering up to 150 days a year.—The bill would alter the way in which enrollees' coinsurance liability for stays in skilled nursing facilities is determined, and would change Medicare's coverage limits from 100 days per spell to 150 days a year. Under current law, coinsurance amounts equal to one-eighth of the hospital deductible amount ($68 per day in 1988) are charged each day for days 21-100 in SNFs during each spell of illness. Under the bill, enrollees would pay coinsurance amounts equal to 15 percent of Medicare's national average reasonable cost for the first ten SNF days each year; enrollees' coinsurance costs would be an estimated $18 per day in 1988 for each coinsurance day.

Fewer than 2 percent of Medicare enrollees have covered SNF stays, but these enrollees will use about 8.6 million SNF days during 1988. These provisions would increase Medicare costs by $175 million in fiscal year 1988. About 80 percent of the costs would be due to lower coinsurance amounts paid by enrollees, while the remaining 20 percent of costs would be due to additional covered SNF days resulting from the change in coverage limits to 150 days a year. The estimate assumes that those enrollees who would exhaust their SNF coverage under current law (about 7,500 in 1988) would use the full 150 days allowed under the bill.

Eliminating the prior hospitalization requirement for SNF stays.—This bill would remove the requirement that a Medicare enrollee be hospitalized for at least three days prior to admission to a SNF to be eligible for Medicare coverage. As a result, the number of people receiving the SNF benefit would increase. Increased costs resulting from this provision are estimated at $35 million for fiscal year 1988, based on findings from a demonstration and study conducted by the Health Care Financing Administration.

Home Health Benefits

Extending home health benefits to 21 consecutive days.—Currently, Medicare enrollees are entitled to receive two to three weeks of daily home health visits. The bill would specify a limit of up to 21 days for most enrollees, and would clarify current law by specifying that "daily care" means up to 7 days a week. The estimated cost of this provision is $4 million for fiscal year 1988. The estimate is based on Medicare administrative data on the distribution of home health visits under current law, and on projections of the in-

creased utilization that would result from clarifying the definition of daily care and increasing the limit on consecutive days.

Extending home health benefits to 45 consecutive days for enrollees following an inpatient stay.—For enrollees who had been discharged from a hospital of SNF within the previous 30 days, this bill would permit up to 45 consecutive days of care. Estimated costs of this provision are $115 million for fiscal year 1988, based on administrative data indicating the proportion of home health users with hospital stays during the year.

Hospice Benefits

The bill would eliminate the current 210-day lifetime limit on the number of days enrollees who are terminally ill may receive hospice services. Nearly 98 percent of hospice beneficiaries die before the 210-day limit is reached, but tabulations by the Health Care Financing Administration indicate that those who survive for the full 210 days of their hospice benefit live another 50 days, on average. Because not all of these additional Medicare costs under the hospice benefit would be offset by reduced costs for inpatient, SNF, or home health services, there would be a small cost due to this provision, equal to about $0.4 million in fiscal year 1988.

Copayment Cap

Each SMI enrollee's liability for copayments under Medicare would be capped at $1,700 in 1988 (but would apply only for the last half of that year). In subsequent years, the value of the copayment cap would increase at the same rate as the third-quarter Consumer Price Index (the Social Security COLA). Under CBO's baseline projections, the COLA would increase by about 4 percent annually over the five-year projection period, so that the copayment cap would be $2,014 in 1992.

About 6 percent (or 1.9 million) of enrollees would be affected by the copayment cap in 1989 (the first year the cap would be fully effective). As a result, Medicare benefit costs would increase by $1.6 billion in fiscal year 1989. By 1992, about 8 percent of enrollees would be affected by the copayment cap.

Counting costs of immunosuppressive drugs toward the copayment cap.—Under current law, Medicare covers the costs of immunosuppressive drugs in the first year following a heart or kidney transplant. This bill would permit the costs of immunosuppressive drugs after the first year to be counted toward the copayment cap (but not covered), effectively reducing the copayment cap for transplants each year. Counting the costs of immunosuppressive drugs toward the cap for the second and third years following a covered transplant would cost about $5 million in fiscal year 1988, rising to $40 million by 1992. (Medicare eligibility ceases three years after a successful transplant.)

Counting costs of certain screening tests toward the copayment cap.—Screening tests and other preventive care are not covered by Medicare under current law. The bill would permit the costs of annual colorectual examinations for enrollees age 65 or more, and of triennial mammorgrams for enrollees age 55 or more, to count toward the copayment cap. This would effectively reduce the copayment cap for enrolles who obtain such tests. About 20 percent of

enrollees currently get annual colorectal examinations, and about 30 percent of female enrollees have periodic mammorgrams. No appreciate utilization increase would be expected under this provision. The estimated costs for this provision are negligible in fiscal year 1988, $20 million in 1989, and $45 million by 1992.

Part B Premiums

This bill would increase the SMI flat premium, and would impose a new supplementary income-related premium administered through the income tax system.

Increasing the flat premium.—In addition to the increases in the premium that would occur under current law to finance current SMI benefits, this bill would introduce a new flat catastrophic premium. For SMI enrollees who were also eligible for HI benefits, the monthly catastrophic premium would be set at $4 for calendar year 1988 (beginning in April of that year), indexed in subsequent years to the rate of growth in catastrophic benefits per enrollees. SMI enrollees who were not eligible for HI benefits would pay a reduced catastrophic premium (about 77 percent of the full permium), reflecting the smaller insurance value of their catastrophic benefits. This premium would generate an estimated $760 million in receipts in fiscal year 1988, offsetting part of the costs of new benefits.

Imposing an income-related supplemental premium.—SMI enrollees with income tax liability of $150 or more would also be required to pay a supplemental premium collected through the income tax system. The supplemental premium rates would be indexed to the rate of growth in catastrophic benefits per enrollees. The total amount paid would depend on each enrollee's income, up to ceiling amounts specified in the bill for each year (intended to ensure that the amount paid would not exceed 65 percent of the subsidy value of Medicare benefits).[1] In 1988, the ceiling on the supplemental premium would be $800 per SMI enrollee. Like receipts from the flat premium, these supplementary premium receipts would be earmarked for the SMI trust fund.

Medicaid Savings from New Medicare Benefits

About 9 percent of Medicare enrollees are dually eligible for Medicaid benefits. For these enrollees, Medicaid generally pays both their copayment liabilities under Medicare and their SMI premium costs. Consequently, Medicaid costs would be reduced by this bill because of lower copayment costs for dually-eligible enrollees, partially offset by increased Medicaid costs for the higher SMI flat premiums. In addition, there would be some additional savings to Medicaid in states with "medically needy" programs because the copayment limitations provided under this bill would reduce the number of Medicare enrollees who would qualify for Medicaid benefits under such programs. Savings are estimated to be $75 million in fiscal year 1988.

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[1] The subsidy value is that portion of Medicare's insurance value that is not paid by enrollees either by prior payroll tax contributions or by premiums.

Medicaid Benefits

This bill would require that states use the Medicaid savings generated by the new Medicare benefits to expand certain Medicaid benefits, for a minimum of 12 quarters. In some states, there would be a lag between receipt of the Medicaid savings and spending for new benefits because such spending would require state legislation. All Medicaid savings for the first three years would be spent by the end of the fifth year in each state, though. Medicaid benefits would increase by an estimated $10 million in fiscal year 1988, rising to a maximum of $295 million in fiscal year 1991, and falling to $65 million in 1992.

AMOUNTS SUBJECT TO APPROPRIATIONS

Administrative Costs of Copayment Cap

Neither Medicare carriers nor the Health Care Financing Administration currently collect information on the amounts of coinsurance paid by enrollees for Part B benefits. To implement the copayment cap proposed in this bill, comprehensive information about both deductible and coinsurance amounts paid under both Parts A and B would have to be compiled across all Medicare carriers for each SMI enrollee. The estimates of start-up and ongoing administrative costs under this proposal are based on discussions with the Bureau of Program Operations in the Health Care Financing Administration.

Annual Notice to Enrollees of Benefits

Under this provision, the Department of Health and Human Services would be required annually to mail each HI or SMI enrollee an explanation of Medicare benefits, beginning with calendar year 1988. Estimated costs for this provision are $4 million annually, based on previous experience with such mailings by the Social Security Administration and by the Health Care Financing Administration.

Studies and Demonstrations

This bill would mandate two studies and one demonstration that would have cost implications. Funding would be provided to the Institute of Medicine to identify additional prescription drugs that might appropriately be either covered by Medicare or counted toward the copayment cap. The Institute would also be funded for a study to explore various private- and public-sector approaches to improving provisions for long-term care. These two studies would cost an estimated $4 million in fiscal year 1988.

The Department of Health and Human Services would be provided with an additional $2 million in fiscal year 1988 to establish six demonstration projects under which peer review organizations would provide case management services to Medicare enrollees with selected catastrophic illnesses.

6. Estimated savings to State and local governments: This bill would have an effect on state and local government budgets, because of the savings that would accrue to state Medicaid programs from the new Medicare benefits and because of the requirement

that states use those savings to expand Medicaid benefits. The net effect is shown below.

[By fiscal years, in millions of dollars]

	1988	1989	1990	1991	1992
Effects on State/local Medicaid costs	−50	−50	−10	−55	−290

7. Estimate comparison: None.
8. Previous CBO estimates: None.
9. Estimate prepared by: Sandra Christensen, Holly Harvey, Don Muse.
10. Estimate approved by: James L. Blum, Assistant Director for Budget Analysis.

VI. REGULATORY IMPACT

Pursuant to paragraph 11(b) of Rule XVI of the Standing Rules of the Senate, the Committee makes the following statement concerning the regulatory impact that might be incurred in carrying out S. 1127 as amended by the Committee.

A. Numbers of Individuals and Businesses Who Would Be Regulated

The bill does not change the numbers of individuals or businesses who would be regulated.

B. Economic Impact of Regulation on Individuals, Consumers, and Business

The bill expands Medicare coverage to cover many expenses currently paid by beneficiaries, either directly or through private supplemental insurance. Beneficiaries will thus be relieved of these financial liabilities. To finance this expanded coverage, all beneficiaries will be required to pay an additional basic monthly premium and some beneficiaries will be required to pay an income-related supplemental premium. The bill will affect consumers who purchase private supplemental insurance by covering under Medicare many of the services now covered by these policies. The bill will likewise affect the business of private supplemental insurance by eliminating some of the beneficiary liability now covered under private policies. Section 13 also changes the standards for voluntary certification of private supplemental policies.

C. Impact on Personal Privacy

The bill does not generally relate to the personal privacy of individuals.

D. Determination of the Amount of Paperwork

Section 9 of the bill adds a requirement for notification to Medicare beneficiaries concerning Medicare coverage. Section 6 of the bill requires notice to beneficiaries of the number of months for which they were enrolled in Part B, and will also necessitate changes in income tax forms and instructions.

VII. ADDITIONAL VIEWS OF MR. WALLOP

As the members of the Finance Committee were approving the catastrophic health insurance bill, S. 1127, the euphoria of this action distracted most members from noticing that the legendary camel was sticking his nose underneath the tent. Indeed, there never has been a larger camel's nose. While dealing with a problem 22 years late, we are building a fabulous new load on the Medicare program, and it may be that last straw that broke the camel's back (in this case, the self-financing Medicare program).

The Chairman of our Committee did a commendable job putting together an Acute Care Health Insurance Program for our retired and disabled citizens. The Committee withstood the pressure to rapidly expand its scope and, worse still, the cost of the program. It is frightening to think what will happen when this bill reaches the floor of the Senate. We side-stepped several blockbuster amendments only by agreeing that these matters will be considered during the Senate's debate or as amendments to other legislation (such as the Budget Reconciliation bill). However, there is a variety of groups and some too willing Senators who are interested in expanding this legislation into a prototype for comprehensive national health insurance.

Just as the Finance Committee was unanimous in reporting this bill, members should also present a united front in rejecting these expansionist inclinations which would destroy what is now a reasonable bill.

The history of the Social Security Act, which includes the Medicare program as Title XVIII, is one of benefit expansion. Over the 52 years of the Act's existence, the Congress has expanded benefits and has expanded the taxes to fund them. Usually, the expanded taxes have lagged behind the new benefits. The strategy has been to argue that some additional benefit is necessary or some group requires coverage under one or more titles of the Act. The cost is minimized. Once the benefit is enacted, then the Social Security Administration actuaries report that the Social Security trust funds are in danger of being bankrupted by the most recent expansion. So, we inevitably expand the taxes rather than review the new demands. Or, in the case of Medicare's Part B premium, we expand the use of General Revenues, which really means enlarging the federal budget deficit.

The Medicare program was enacted with one specific mission. Its task was to provide, on a cost-sharing basis with beneficiaries, insurance coverage for acute care hospital and physician services. It can be argued that the original focus of Medicare should have been on protecting the elderly from health care catastrophies rather than short term acute care. That is a concept we have been trying to catch up with since 1965.

Three funding sources were created for this federal acute care insurance. The hospital services, which have accounted for two thirds of program costs, are funded by a payroll tax. Physician services are funded by participants' premiums and general revenues. When Medicare became law in 1965, it was proclaimed to be on sound financial footing. The program cost $64 million in its first year. Just two years later, the cost quadrupled to $4.7 billion. The program was in trouble, and payroll taxes were increased. Five years later, another, substantial, increase in taxes was enacted. The cost of Medicare has constantly exceeded projections. By the time we reached the 20th anniversary of the program, the costs were about eight times the original projections by the program actuaries. When President Reagan took office in 1981, Medicare cost $32 billion. This year, the cost will have more than doubled, to $73 billion. While program costs were understated by proponents to ensure passage of the original legislation, there was also a failure to truly appreciate actual cost of benefits. We may fall into that same trap with this new coverage.

The Congress has previously expanded benefits with costly results. For instance, in 1972, coverage was provided to the disabled and those receiving kidney dialysis (ESRD). Since a disabled beneficiary, on average, has costs about 30 percent higher than retired beneficiaries, this coverage increased costs well beyond the simple increase in participants. The ESRD benefit had an explosive and unexpected price tag. We have reined in the ESRD benefit, but only because we were forced to do so through the budget reconciliation process.

Now, we are about to provide the second major expansion of the program. Make no mistake, this is an expansion of benefits rather than participants. Many have mislabeled our legislation as a catastrophic health insurance bill. Such a label suggests that whenever a beneficiary experiences an illness requiring high cost medical care, this catastrophic insurance will pay for such care. That is the objective of those who preach an expansionist view of the Social Security program. It may be the expectation of those who take our title at face value. It will become the demand of politics and expectation.

S. 1127 does not, I repeat does not, provide catastrophic health insurance. It is simply a fill-in of the holes left in the acute care insurance that is Medicare. Medicare has cost sharing and deductibles for every length of stay in a hospital. Medicare also has a limit on the number of days in a hospital covered by this insurance. The Committee bill expands Medicare to provide unlimited days of stay in a hospital for an illness and limits the out of pocket payments by participants to the hospital and physician for their care. It is an extended acute care benefit, not a catastrophic health package.

Two points need to be emphasized. First, the expanded benefit preempts private Medigap policies which provided similar health insurance coverage. About 70 percent of Medicare beneficiaries now have this private insurance. This insurance provided by the marketplace will be eliminated in return for insurance provided by the federal government. Of those who had no Medigap insurance, about half are covered by Medicare. Thus, this legislation ultimately benefits only about 10 percent of the population who are not cov-

ered by Medicaid and have not purchased Medigap insurance. This legislation will not improve benefit coverage for most Medicare participants. Only about 3 percent of those covered by Medicare will actually utilize this benefit in any one year.

The second point is that this benefit is related to a hospital stay based on illness. Many Medicare beneficiaries now believe that Medicare provides a full range of health benefits, even to include nursing home care. That is a misconception which will be further enhanced by this misnamed "catastrophic" health insurance bill. Medicare only covers about 44 percent of the health care costs of the elderly. It does not cover prescription drugs, dental services, many mental health services, nor does it cover custodial care in a nursing home. This bill will not cover any of those services either. These are the types of services the expansionists want Medicare to provide. They want to totally replace individual responsibility and the private marketplace with government-provided care. And the cost—well, they don't worry about the cost. It can be financed by deficit spending or higher taxes.

Now that the federal government will be committed to cover the cost of catastrophic illness, no limiting principle will define the proper role of government in providing health care. Future debates will involve how to make federal catastrophic care more comprehensive.

The bill considered by the House of Representatives has a prescription drug benefit tailing along. It would be funded by higher taxes (through increased premiums), but would have a $3 billion estimated deficit in just eight years. This would be covered by deficit spending, rhetoric on deficits notwithstanding. Long term nursing care is projected to cost between $30 and $50 billion. The premium to finance such a benefit would be astronomical.

The financing of S. 1127 will present a real challenge to fiscal responsibility. I fear the proposed financing mechanisms will prove to be inadequate to support future benefit costs. While the program costs are directly linked to premiums, as costs escalate, this linkage could be severed. Unfortunately, we already have a precedent with the Part B premium for shifting costs to General Revenues.

It is this same Part B Premium which is used to finance the new benefit. The basic premium would be increased, and a new supplemental premium, labeled a "means test," is added. Means tests are traditionally used to limit access. This supplemental premium is used to shift costs on an intragenerational basis. It is actually a progressive tax which reflects redistributive tendencies of the Congress. And, if both premiums fail to fund this benefit, we will undoubtedly revert to old habits and use General Revenues to fund Part B services.

Our ability to resist financing through General Revenues is usually found wanting, as demonstrated by past decisions to let the Part B Premium slip. Using general revenues, rather than user fees, is always a tempting political solution for providing new government services. Since the passage of the Social Security Act, there has been an effort to fund part of the entire program—retirement benefits as well health benefits—through General Revenues.

It is not surprising that General Revenue financing is again a prospect. But, it would be wrong to allow this provision to break

with self-financing and budget neutrality. I would hope that the principle of the user pays would not be violated in this legislation, but this camel's nose like Pinocchio's is predicted to grow.

The Committee has decided that this is an appropriate direction for federal health care policy. But, how do we constrain this new endeavor? Will we have reasonable and meaningful limitations on the scope of federal catastrophic care? Will we continue to recognize private insurance and savings as the bulwark of health care financing? Will we allow health care expenditures to absorb more and more of our GNP? We hope that the 100th Congress will have the correct responses to these questions.

As was demonstrated during our Committee's discussions, S. 1127 opens up a far reaching ethical, social and economic debate. That is the question of the extent to which we, as a society, will provide whatever care is necessary to prolong life. This debate was broached by a very brief discussion of the treatment of those who suffer from AIDS. It was also recently raised by the recent HCFA regulations for Medicare coverage of heart transplants. The fundamental question is whether through public policy (and public financing) we will provide whatever health care people demand regardless of cost.

What type of limits, formal and informal, will we place on health services? That is a debate we will have to face some day soon. It will most likely be one of the most difficult issues ever confronted by the Congress. The camel lying behind the nose is the expectation created that each American has the right, almost theological in its dimension, to the full scientific ability of the world to prolong his life and comfort regardless of cost. From organ transplants to mechanical transplants, from exotic rare procedures to experimental science, citizens will expect and politicians may respond.

I would like to reiterate a recent statement by Dr. Bowen. It is a challenge to design an acute care benefit that is affordable to beneficiary, taxpayer and government alike—a program that needs no new taxes, no new bureaucracy, is budget neutral and does not exacerbate the deficit or problems of the Medicare trust funds. The Finance Committee bill does a respectable job of meeting this challenge. Adding unrelated baggage during Senate debate or adopting provisions in the House bill in Conference would most likely sink this proposal or the country. The Senate, in this bicentennial session, has yet to demonstrate that as a body it is committed to fiscal responsibility. Our actions on S. 1127 will demonstrate how serious we are about legislating in a responsible fashion.

MALCOLM WALLOP.

VIII. ADDITIONAL VIEWS OF MR. ARMSTRONG

In some respects, S. 1127 is about 22 years late. A good case can be made that the most appropriate Federal health care program from the start would have been one to protect the elderly from catastrophic illness rather than the kind of short term acute care costs routinely incurred in hospitals. Now, after spending over $500 billion since 1965 on acute care, Congress is ready to implement some measure of catastrophic protection.

S. 1127, as reported, is a reasonable response to President Reagan's catastrophic care proposal. But before the Senate enacts the bill, or significantly expand its scope, I hope my colleagues will reflect on several potential concerns.

First, once the Federal Government makes a commitment to cover the cost of "catastrophic" illness, no limiting principle will exist to define its proper role in providing health care. In the years ahead, the debate will be on how to make catastrophic care more comprehensive. The burden that individuals and private insurance should bear in providing for health care needs is apt to be given less consideration. In short, the legislation holds out the prospect of an ever-expanding Federal role in health insurance.

It's no great mystery why this might occur. Many Medicare beneficiaries already expect the program to provide a full range of benefits. S. 1127, though bearing the label of "catastrophic" care, retains the present focus of Medicare on acute ailments. As has been well noted, the bill does not address the true source of catastrophic costs, such as long term nursing care which is now prohibitively expensive. Pressure will surely mount to move catastrophic care in this direction.

Second, even if catastrophic care were limited to the reasonable provisions of S. 1127, I have great confidence in Congress' ability to underestimate the program's cost. Last year, health care inflation exceeded the increase in consumer prices by a 7 to 1 ratio last year. That fact, combined with increased utilization due to an aging population and the development of new and expensive medical technology, may conspire to increase costs well beyond what Congress anticipates today.

Proposed financing mechanisms are unlikely to prove adequate to support future benefit costs. While a direct premium linked to costs is sensible, Congress will quickly end that linkage when costs start to escalate. It's also unlikely beneficiaries will easily accept the euphemism of the so-called "supplemental premium." It is really a progressive tax (did someone say "means-test"?) on some to pay for the catastrophic benefits of others. That is not "insurance", but the usual benefit redistribution scheme Congress is adept at establishing. The fact the transfer is "intragenerational" sounds equitable, but Congress will face strenuous pressure to control it.

History supports these concerns. Medicare was created in 1966, supposedly on a sound footing. The program cost $64 million that year. Just 2 years later, the cost quadrupled to $4.7 billion and, in the face of financial trouble, payroll taxes were increased. Five years later, they were increased again. The cost of Medicare has constantly exceeded projections. At its 20 year anniversary, the program was eight times its original projections. When President Reagan took office in 1981, Medicare cost $32 billion. This year, the cost will be more than double that, $73 billion. By 1990, the program will exceed $100 billion. Congress has clearly demonstrated its inability to control Medicare expenditure, and will probably do so again.

The result, in the not too distant future, will be as follows: catastrophic care payments will greatly exceed expectations and revenues will fall short. The HI trust fund, which already faces bankruptcy in the 1990s, will suffer further, along with the overall Federal budget deficit.

But once this program assumes its inevitable sacred cow status, they'll be little chance of curbing benefits. Any move to control costs will likely involve more extensive Federal control and regulation of providers than exists even today. There will also be considerable pressure to raise revenues from any source—payroll taxes, general revenues, excise taxes—to pay for benefits. When that occurs, the hope this program would remain self-financing and budget neutral will fade away.

Indeed, to some extent, the concept of budget neutrality is already irrelevant: it's easy to propose spending and taxes at equally higher levels. Even if Congress finds a way to keep the program self-financing, the Federal Government will end up consuming substantially more private resources—bad news for Americans trying to save money for health care needs. Ultimately, not only might this initiative end up supplanting existing private Medigap policies, which now cover Medicare copayments, it might also establish disincentives for private savings and insurance to cover health care needs.

Congress should carefully consider whether this is an appropriate direction for Federal health care policy and whether reasonable and meaningful limits on the scope of Federal catastrophic care should be put in place. Congress should also continue to promote private insurance and savings as the principle means of health care financing in this country. Otherwise, our Nation may be heading down a road of vast expenditures, vast taxation, and excessive regulation with potentially ruinous consequences on our Nation's health care industry.

Again, history is instructive. Since 1965, the Federal Government has spent $517 billion on Medicare and another $346 billion on other Federal health care programs. From 1987 to 1992, another $602 billion will be spent on Medicare and $302 billion on other health care under existing reimbursement policies. What have we gotten for the $850 billion spent over the last 20 years? What will we get for the $900 billion that would be spent by 1992 even without this bill? Many elderly citzens have far greater access to health care than in 1965, and that is surely a great accomplishment. But it is clear the Nation has faced rampant inflation in health care,

largely driven by Federal expenditures and reimbursement policies, and gained a huge health care regulatory bureaucracy on which hospitals and doctors have become ensnared and dependent.

The Federal Government can play a positive role in providing for the catastrophic health care needs of our citizens. Congress should also preserve and cultivate an expanding private role in protecting Americans from catastrophic illness and in encouraging individuals to plan and save for their health care needs. This legislation is well intentioned and, thus far at least, reasonably crafted. But it holds the seeds of its own destruction. I hope my colleagues will carefully consider these concerns as the Senate debates this measure and amendments to greatly expand its scope.

WILLIAM ARMSTRONG.

IX. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

Pursuant to the requirements of paragraph 12 of Rule XXVI of the Standing Rules of the Senate, changes in existing law made by the bill S. 1127, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

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TITLE XI—GENERAL PROVISIONS AND PEER REVIEW

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[PROGRAM FOR DETERMINING QUALIFICATIONS FOR CERTAIN HEALTH CARE PERSONNEL

[SEC. 1123. (a) The Secretary, in carrying out his functions relating to the qualifications for health care personnel under title XVIII, shall develop (in consultation with appropriate professional health organizations and State health and licensure agencies) and conduct (in conjunction with State health and licensure agencies) until September 30, 1987, a program designed to determine the proficiency of individuals (who do not otherwise meet the formal educational, professional membership, or other specific criteria established for determining the qualifications of practical nurses, therapists, laboratory technicians, and technologists, and cytotechnologists, X-ray technicians, psychiatric technicians, or other health care technicians and technologists) to perform the duties and functions of practical nurses, therapists, laboratory technichians, technologists, and cytotechnologists, X-ray technicians, psychiatric technicians, or other health care technicians and technologists. Such program shall include (but not be limited to) the employment of procedures for the formal testing of the proficiency of individuals. In the conduct of such program, no individual who otherwise meets the proficiency requirements for any health care specialty shall be denied a satisfactory proficiency rating solely because of his failure to meet formal educational or professional membership requirements.

[(b) If any individual has been determined, under the program established pursuant to subsection (a), to be qualified to perform the duties and functions of any health care specialty, no person or provider utilizing the services of such individual to perform such duties and functions shall be denied payment, under title XVIII or under any State plan approved under title XIX, for any health care

services provided by such person on the grounds that such individual is not qualified to perform such duties and functions.]

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

DESCRIPTION OF PROGRAM

SEC. 1811. The insurance program for which entitlement is established by sections 226 and 226A provides basic protection against the costs of hospital, [related post-hospital] *extended care services,* home health services, and hospice care in accordance with this part for (1) individuals who are age 65 or over and are eligible for retirement benefits under title II of this Act (or would be eligible for such benefits if certain government employment were covered employment under such title) or under the railroad retirement system, (2) individuals under age 65 who have been entitled for not less than 24 months to benefits under title II of this Act (or would have been so entitled to such benefits if certain government employment were covered employment under such title) or under the railroad retirement system on the basis of a disability, and (3) certain individuals who do not meet the conditions specified in either clause (1) or (2) but who are medically determined to have end stage renal disease.

[SCOPE OF BENEFITS

[SEC. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d)(2) to him (subject to the provisions of this part) for—

[(1) inpatient hospital services for up to 150 days during any spell of illness minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

[(2)(A) post-hospital extended care services for up to 100 days during any spell of illness, and (B) to the extent provided in subsection (f), extended care services that are not post-hospital extended care services;

[(3) home health services; and

[(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each [and one subsequent period of 30 days], *a subsequent period of 30 days, and a subsequent extension period* with respect to which the individual makes an election under subsection (d)(1).

[(b) Payment under this part for services furnished an individual during a spell of illness may not (subject to subsection (c)) be made for—

[(1) inpatient hospital services furnished to him during such spell after such services have been furnished to him for 150 days during such spell minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

[(2) post-hospital extended care services furnished to him during such spell after such services have been furnished to him for 100 days during such spell; or

[(3) inpatient psychiatric hospital services furnished to him after such services have been furnished to him for a total of 190 days during his lifetime.

[(c) If an individual is an inpatient of a psychiatric hospital on the first day of the first month for which he is entitled to benefits under this part, the days on which he was an inpatient of such a hospital in the 150-day period immediately before such first day shall be included in determining the number of days limit under subsection (b)(1) insofar as such limit applies to (1) inpatient psychiatric hospital services, or (2) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness (but shall not be included in determining such number of days limit insofar as it applies to other inpatient hospital services or in determining the 190-day limit under subsection (b)(3)).

[(d)(1) Payment under this part may be made for hospice care provided with respect to an individual only during two periods of 90 days each [and one subsequent period of 30 days], *a subsequent period of 30 days, and a subsequent extension period* during the individual's lifetime and only, with respect to each such period, if the individual makes an election under this paragraph to receive hospice care under this part provided by, or under arrangements made by, a particular hospice program instead of certain other benefits under this title.

[(2)(A) Except as provided in subparagraphs (B) and (C) and except in such exceptional and unusual circumstances as the Secretary may provide, if an individual makes such an election for a period with respect to a particular hospice program, the individual shall be deemed to have waived all rights to have payment made under this title with respect to—

[(i) hospice care provided by another hospice program (other than under arrangements made by the particular hospice program) during the period, and

[(ii) services furnished during the period that are determined (in accordance with guidelines of the Secretary) to be—

[(I) related to the treatment of the individual's condition with respect to which a diagnosis of terminal illness has been made or

[(II) equivalent to (or duplicative of) hospice care;

except that clause (ii) shall not apply to physicians' services furnished by the individual's attending physician (if not an employee of the hospice program) or to services provided by (or under arrangements made by) the hospice program.

[(B) After an individual makes such an election with respect to a 90- or 30-day period *or a subsequent extension period*, the individual may revoke the election during the period, in which case—

[(i) the revocation shall act as a waiver of the right to have payment made under this part for any hospice care benefits for the remaining time in such period and (for purposes of subsection (a)(4) and subparagraph (A)) the individual shall be deemed to have been provided such benefits during such entire period, and

[(ii) the individual may at any time after the revocation execute a new election for a subsequent period, if the individual otherwise is entitled to hospice care benefits with respect to such a period.

[(C) An individual may, once in each such period, change the hospice program with respect to which the election is made and such change shall not be considered a revocation of an election under subparagraph (B).

[(D) For purposes of this title, an individual's election with respect to a hospice program shall no longer be considered to be in effect with respect to that hospice program after the date the individual's revocation or change of election with respect to that election takes effect.

[(e) For purposes of subsections (b) and (c), in patient hospital services, inpatient psychiatric hospital services, and post-hospital extended care services shall be taken into account only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1814(a), made with respect to such services under this part.

[(f)(1) The Secretary shall provide for coverage, under clause (B) of subsection (a)(2), of extended care services which are not post-hospital extended care services at such time and for so long as the Secretary determines, and under such terms and conditions (described in paragraph (2)) as the Secretary finds appropriate, that the inclusion of such services will not result in any increase in the total of payments made under this title and will not alter the acute care nature of the benefit described in subsection (a)(2).

[(2) The Secretary may provide—

[(A) for such limitations on the scope and extent of services described in subsection (a)(2)(B) and on the categories of individuals who may be eligible to receive such services, and

[(B) notwithstanding sections 1814, 1861(v), and 1886, for such restrictions and alternatives on the amounts and methods of payment for services described in such subsection,

as may be necessary to carry out paragraph (1).

[(g) For definition of "spell of illness", and for definitions of other terms used in this part, see section 1861.

SCOPE OF BENEFITS FOR INDIVIDUALS COVERED UNDER PARTS A AND B

SEC. 1812. (a) The benefits provided by the insurance program under this part to an individual who is covered by such program and by the insurance program under part B shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d)(2) to him (subject to the provisions of this part) for—

(1) inpatient hospital services;

(2) extended care services for up to 150 days during any calendar year;

(3) home health services; and

(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each [and one subsequent period of 30 days], a subsequent period of 30 days, and a subsequent extension period with respect to which the individual makes an election under subsection (c)(1).

(b) Payment under this part for services furnished to an individual who is covered by the insurance programs established under this part and part B may not be made for—

(1) extended care services furnished to him during a calendar year after such services have been furnished to him for 150 days during that year; or

(2) inpatient psychiatric hospital services furnished to him after such services have been furnished to him for a total of 190 days during his lifetime.

(c)(1) Payment under this part may be made for hospice care provided with respect to an individual only during two periods of 90 days each and one subsequent period of 30 days during the individual's lifetime and only, with respect to each such period, if the individual makes an election under this paragraph to receive hospice care under this part provided by, or under arrangements made by, a particular hospice program instead of certain other benefits under this title.

(2)(A) Except as provided in subparagraphs (B) and (C) and except in such exceptional and unusual circumstances as the Secretary may provide, if an individual makes such an election for a period with respect to a particular hospice program, the individual shall be deemed to have waived all rights to have payment made under this title with respect to—

(i) hospice care provided by another hospice program (other than under arrangements made by the particular hospice program) during the period, and

(ii) services furnished during the period that are determined (in accordance with guidelines of the Secretary) to be—

(I) related to the treatment of the individual's condition with respect to which a diagnosis of terminal illness has been made, or

(II) equivalent to (or duplicative of) hospice care;

except that clause (ii) shall not apply to physicians' services furnished by the individual's attending physician (if not an employee of the hospice program) or to services provided by (or under arrangements made by) the hospice program.

(B) After an individual makes such an election with respect to a 90- or 30-day period, the individual may revoke the election during the period, in which case—

(i) the revocation shall act as a waiver of the right to have payment made under this part for any hospice care benefits for the remaining time in such period and (for purposes of subparagraph (A), subsection (a)(4), and section 1812A(a)(4)) the individual shall be deemed to have been provided such benefits during such entire period, and

(ii) the individual may at any time after the revocation execute a new election for a subsequent period, if the individual otherwise is entitled to hospice care benefits with respect to such a period.

(C) An individual may, once in each such period, change the hospice program with respect to which election is made and such change shall not be considered a revocation of an election under subparagraph (B).

(D) For purposes of this title, an individual's election with respect to a hospice program shall no longer be considered to be in effect with respect to that hospice program after the date the individual's revocation or change of election with respect to that election takes effect.

(d) For purposes of subsection (b), inpatient psychiatric hospital services and extended care services shall be taken into account only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1814(a), made with respect to such services under this part.

SCOPE OF BENEFITS FOR INDIVIDUALS COVERED UNDER PART A ONLY

SEC. 1812A. (a) The benefits provided by the insurance program under this part to an individual who is covered by such program but not by the insurance program under part B shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d)(2) to him (subject to the provisions of this part) for—

(1) inpatient hospital services for up to 150 days during any spell of illness minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless the individual specifies in accordance with regulations of the Secretary that the individual does not desire to have such payment made);

(2)(A) post-hospital extended care services for up to 100 days during any spell of illness, and (B) to the extent provided in subsection (f), extended care services that are not post-hospital extended care services;

(3) home health services; and

(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each [and one subsequent period of 30 days], a subsequent period of 30 days, and a subsequent extension period with respect to which the individual makes an election under section 1812(c)(1).

(b) Payment under this part for services furnished during a spell of illness to an individual who is covered by the insurance program under this part but not by the insurance program under part B may not (subject to subsection (c)) be made for—

(1) inpatient hospital services furnished to the individual during such spell after such services have been furnished to the individual for 150 days during such spell minus 1 day for each day of inpatient hospital services in excess of 90 days received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

(2) post-hospital extended care services furnished to the individual during such spell after such services have been furnished to the individual for 100 days during such spell; or

(3) inpatient psychiatric hospital services furnished to the individual after such services have been furnished to the individual for a total of 190 days during the lifetime of the individual.

(c) If an individual is an inpatient of a psychiatric hospital on the first day of the first month for which he is entitled to benefits under this part, the days on which he was an inpatient of such a hospital in the 150-day period immediately before such first day shall be included in determining the number of days limit under subsection (b)(1) insofar as such limit applies to (1) inpatient psychiatric hospital services, or (2) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness (but shall not be included in determining such number of days limit insofar as it applies to other inpatient hospital services or in determining the 190-day limit under subsection (b)(3)).

(d) The provisions of section 1812(c) shall apply to individuals who are covered by the insurance program under this part but not by the insurance program under part B in the same manner and to the same extent as those provisions apply to individuals who are covered under both such programs.

(e) For purposes of subsections (b) and (c), inpatient hospital services, inpatient psychiatric hospital services, and post-hospital extended care services shall be taken into account only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1814(a), made with respect to such services under this part.

(f)(1) The Secretary shall provide for coverage, under subsection (a)(2)(B), of extended care services which are not post-hospital extended care services at such time and for so long as the Secretary determines, and under such terms and conditions (described in paragraph (2)) as the Secretary finds appropriate, that the inclusion of such services will not result in any increase in the total of payments made under this title and will not alter the acute care nature of the benefit described in subsection (a)(2).

(2) The Secretary may provide—

(A) for such limitations on the scope and extent of services described in subsection (a)(2)(B) and on the categories of individuals who may be eligible to receive such services, and

(B) notwithstanding sections 1814, 1861(v), and 1886, for such restrictions and alternatives on the amounts and methods of payment for services described in such subsection,

as may be necessary to carry out paragraph (1).

[DEDUCTIBLES AND COINSURANCE

[SEC. 1813. (a)(1) The amount payable for inpatient hospital services furnished an individual during any spell of illness shall be reduced by a deduction equal to the inpatient hospital deductible or, if less, the charges imposed with respect to such individual for such services, except that, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed. Such amount shall be further reduced by a coinsurance amount equal to—

[(A) one-fourth of the inpatient hospital deductible for each day (before the 91st day) on which such individual is funished such services during such spell of illness after such services have been furnished to him for 60 days during such spell; and

[(B) one-half of the inpatient hospital deductible for each day (before the day following the last day for which such individual is entitled under section 1812(a)(1) to have payment made on his behalf for inpatient hospital services during such spell of illness) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 90 days during such spell;

except that the reduction under this sentence for any day shall not exceed the charges imposed for that day with respect to such individual for such services (and for this purpose, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed).

[(2) The amount payable to any provider of services under this part for services furnished an individual during any spell of illness shall be further reduced by a deduction equal to the cost of the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to him as part of such services during such spell of illness.

[(3) The amount payable for post-hospital extended care services furnished an individual during any spell of illness shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day (before the 101st day) on which he is furnished such services after such services have been furnished to him for 20 days during such spell.

[(4)(A) The amount payable for hospice care shall be reduced—

[(i) in the case of drugs and biologicals provided on an outpatient basis by (or under arrangements made by) the hospice program, by a coinsurance amount equal to an amount (not to exceed $5 per prescription) determined in accordance with a drug copayment schedule (established by the hospice program) which is related to, and approximates 5 percent of, the cost of the drug or biological to the program, and

[(ii) in the case of respite care provided by (or under arrangements made by) the hospice program, by a coinsurance

amount equal to 5 percent of the amount estimated by the hospice program (in accordance with regulations of the Secretary) to be equal to the amount of payment under section 1814(i) to that program for respite care;

except that the total of the coinsurance required under clause (ii) for an individual may not exceed for a hospice coinsurance period the inpatient hospital deductible applicable for the year in which the period began. For purposes of this subparagraph, the term "hospice coinsurance period" means, for an individual, a period of consecutive days beginning with the first day for which an election under section 1812(d) is in effect for the individual and ending with the close of the first period of 14 consecutive days on each of which such an election is not in effect for the individual.

[(B) During the period of election by an individual under section 1812(d)(1), no copayments or deductibles other than those under subparagraph (A) shall apply with respect to services furnished to such individual which constitute hospice care, regardless of the setting in which such services are furnished.

[(b)(1) The inpatient hospital deductible for 1987 shall be $520. The inpatient hospital deductible for any succeeding year shall be an amount equal to the inpatient hospital deductible for the preceding calendar year, changed by the applicable percentage increase (as defined in section 1886(b)(3)(B)) which is applied under section 1886(d)(3)(A) for discharges in the fiscal year that begins on October 1 of such preceding calendar year, and adjusted to reflect changes in real case mix (determined on the basis of the most recent case mix data available). Any amount determined under the preceding sentence which is not a multiple of $4 shall be rounded to the nearest multiple of $4 (or, if it is midway between two multiples of $4, to the next higher multiple of $4).

[(2) The Secretary shall promulgate the inpatient hospital deductible and all coinsurance amounts under this section between September 1 and September 15 of the year preceding the year to which they will apply.

[(3) The inpatient hospital deductible for a year shall apply to—

[(A) the deduction under the first sentence of subsection (a)(1) for the year in which the first day of inpatient hospital services occurs in a spell of illness, and

[(B) to the coinsurance amounts under subsection (a) for inpatient hospital services and post-hospital extended care services furnished in that year.]

DEDUCTIBLES AND COINSURANCE FOR INDIVIDUALS COVERED UNDER PARTS A AND B

SEC. 1813. (a)(1)(A) Subject to subparagraph (C), the amount payable for inpatient hospital services furnished to an individual who is covered by the insurance programs under this part and part B during the individual's first period of hospitalization to begin during a calendar year shall be reduced by a deduction equal to the inpatient hospital deductible for that year or, if less, the charges imposed with respect to such individual for such services, except that, if the customary charges for such services are greater than the

charges so imposed, such customary charges shall be considered to be the charges so imposed.

(B) For purposes of subparagraph (A), the term "period of hospitalization" means, with respect to an individual, the period beginning on the first day the individual is furnished inpatient hospital services and ending on the individual's date of discharge (as established by the Secretary for purposes of section 1886) from the hospital (or, in the case of a transfer, hospitals) involved.

(C) In the case of an individual with respect to whom—

(i) a period of hospitalization begins during December of any calendar year,

(ii) an inpatient hospital deductible is imposed with respect to such period of hospitalization, and

(iii) a period of hospitalization begins during January of the following calendar year,

no inpatient hospital deductible shall be imposed with respect to a period of hospitalization beginning in January of such following year (and such period of hospitalization shall not be taken into account in determining the application of an inpatient hospital deductible to any period of hospitalization beginning for such individual after January 31 of such following year).

(2) The amount payable to any provider of services under this part for services furnished during any calendar year to an individual who is covered by the programs established under this part and part B shall be further reduced by a deduction equal to the cost of the first 3 pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to him as part of such services during that year.

(3)(A) The amount payable for extended care services furnished in any calendar year to an individual who is covered by the insurance programs established under this part and part B shall be reduced by the coinsurance amount (promulgated under subparagraph (C) for that year) for each of the first 10 days on which he is furnished such services during any stay in a skilled nursing facility, but in no event shall a coinsurance amount be imposed under this paragraph with respect to an individual for more than 10 days in any calendar year.

(B) Before September 1 of each year (beginning with 1987), the Secretary shall estimate the national average per diem reasonable cost recognized under this title for extended care services that will be furnished in the succeeding calendar year.

(C) The Secretary shall, in September of each year (beginning with 1987) promulgate the coinsurance amount that shall apply to extended care services furnished in the succeeding year. Such amount shall be equal to 15 percent of the national average per diem cost estimated under subparagraph (B) for that year. If the coinsurance amount determined under the preceding sentence is not a multiple of $1, it shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

(4)(A) The amount payable for hospice care shall be reduced—

(i) in the case of drugs and biologicals provided on an outpatient basis by (or under arrangements made by) the hospice program, by a coinsurance amount equal to an amount (not to

exceed $5 per prescription) determined in accordance with a drug copayment schedule (established by the hospice program) which is related to, and approximates 5 percent of, the cost of the drug or biological to the program, and

(ii) in the case of respite care provided by (or under arrangements made by) the hospice program, by a coinsurance amount equal to 5 percent of the amount estimated by the hospice program (in accordance with regulations of the Secretary) to be equal to the amount of payment under section 1814(i) to that program for respite care;

except that the total of the coinsurance required under clause (ii) for an individual may not exceed for a hospice coinsurance period the inpatient hospital deductible applicable for the year in which the period began. For purposes of this subparagraph, the term "hospice coinsurance period" means, for an individual, a period of consecutive days beginning with the first day for which an election under section 1812(c) is in effect for the individual and ending with the close of the first period of 14 consecutive days on each of which such an election is not in effect for the individual.

(B) During the period of an election by an individual under section 1812(c)(1), no copayments or deductibles other than those under subparagraph (A) shall apply with respect to services furnished to such individual which constitute hospice care, regardless of the setting in which such services are furnished.

(b)(1) The inpatient hospital deductible for 1987 shall be $520. The inpatient hospital deductible for any succeeding year shall be an amount equal to the inpatient hospital deductible for the preceding calendar year, changed by the applicable percentage increase (as defined in section 1886(b)(3)(B)) which is applied under section 1886(d)(3)(A) for discharges in the fiscal year that begins on October 1 of such preceding calendar year, and adjusted to reflect changes in real case mix (determined on the basis of the most recent case mix data available). Any amount determined under the preceding sentence which is not a multiple of $4 shall be rounded to the nearest multiple of $4 (or, if it is midway between two multiples of $4, the next higher multiple of $4).

(2) The Secretary shall promulgate the inpatient hospital deductible and all coinsurance amounts under this section between September 1 and September 15 of the year preceding the year to which they will apply.

DEDUCTIBLES AND COINSURANCE AMOUNTS FOR INDIVIDUALS COVERED UNDER PART A ONLY

SEC. 1813A. (a)(1) The amount payable for inpatient hospital services furnished during any spell of illness to an individual who is covered by the insurance program under this part but not by the insurance program under part B shall be reduced by a deduction equal to the inpatient hospital deductible or, if less, the charges imposed with respect to such individual for such services, except that, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed. Such amount shall be further reduced by a coinsurance amount equal to—

(A) one-fourth of the inpatient hospital deductible for each day (before the 91st day) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 60 days during such spell; and

(B) one-half of the inpatient hospital deductible for each day (before the day following the last day for which such individual is entitled under section 1812A(a)(1) to have payment made on his behalf for inpatient hospital services during such spell of illness) on which such individual is furnished such services during such spell of illness after such services have been furnished to him for 90 days during such spell;

except that the reduction under this sentence for any day shall not exceed the charges imposed for that day with respect to such individual for such services (and for this purpose, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed).

(2) The amount payable to any provider of services under this part for services furnished during any spell of illness to an individual who is covered by the insurance program under this part but not by the insurance program under part B shall be further reduced by a deduction equal to the cost of the first 3 pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to him as part of such services during such spell of illness.

(3) The amount payable for post-hospital extended care services furnished during any spell of illness to an individual who is covered by the insurance program under this part but not by the insurance program under part B shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day (before the 101st day) on which the individual is furnished such services after such services have been furnished to the individual for 20 days during such spell.

(b) The provisions of section 1813(a)(4) shall apply to individuals who are covered by the insurance program under this part but not by the insurance program under part B in the same manner and to the same extent as those provisions apply to individuals covered under both such programs.

(c)(1) For purposes of this section, the "inpatient hospital deductible" for a year is the inpatient hospital deductible promulgated under section 1813 for that year.

(2) The inpatient hospital deductible for a year shall apply to—

(A) the deduction under the first sentence of subsection (a)(1) for the year in which the first day of inpatient hospital services occurs in a spell of illness, and

(B) to the coinsurance amounts under subsection (a) for inpatient hospital services and post-hospital extended care services furnished in that year.

CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

Requirement of Requests and Certifications

SEC. 1814. (a) Except as provided in subsections (d) and (g) and in section 1876, payment for services furnished an individual may be

made only to providers of services which are eligible therefor under section 1866 and only if—

* * * * * * *

(2) a physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

* * * * * * *

(B)(*i*) in the case of post-hospital extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitation services, which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis, for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) prior to transfer to the skilled nursing facility or for a condition requiring such extended care services which arose after such transfer and while he was still in the facility for treatment of the condition or conditions for which he was receiving such inpatient hospital services[;], *and*

(ii) in the case of extended care services, such services are or were required to be given because the individual needs or needed on a daily basis skilled nursing care (provided directly by or requiring the supervision of skilled nursing personnel) or other skilled rehabilitative services, which as a practical matter can only be provided in a skilled nursing facility;

* * * * * * *

(6) with respect to inpatient hospital services, *extended care services,* or post-hospital extended care services furnished such individual during a continuous period, a finding has not been made (by the physician members of the committee or group, as described in section 1861(k)(4), including any finding made in the course of a sample or other review of admissions to the institution) pursuant to the system of utilization review that further inpatient hospital services, *further extended care services,* or further post-hospital extended care services, as the case may be, are not medically necessary; except that, if such a finding has been made, payment may be made for such services furnished before the 4th day after the day on which the hospital or skilled nursing facility, as the case may be, received notice of such finding; and

(7) in the case of hospice care provided an individual—

(A)(i) in the first 90-day period—

(I) the individual's attending physician (as defined in section 1861(dd)(3)(B)), and

(II) the medical director (or physician member of the interdisciplinary group described in section 1861(dd)(2)(B)) of the hospice program providing (or arranging for) the care,

each certify, not later than two days after hospice care is initiated, that the individual is terminally ill (as defined in section 1861(dd)(3)(A)), [and]

(ii) in a subsequent 90- or 30-day period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill[;], *and*

(iii) in a subsequent extension period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill;

* * * * * * *

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes certification of the kind provided in subparagraph (A), (B), (C), or (D) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary). For purposes of the preceding sentence, service by a physician as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency. *For purposes of paragraph (2)(C), an individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker) or if the indivudual has a condition such that leaving his or her home is medically contra-indicated. While an individual does not have to be bedridden to be considered "confined to his home", the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires a consid-*

erable and taxing effort by the individual, and that absences of the individual from home are infrequent or of relatively short duration.

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Amount Paid to Providers

(b) The amount paid to any provider of services (other than a hospice program providing hospice care and other than a home health agency with respect to durable medical equipment) with respect to services for which payment may be made under this part shall, subject to the provisions of sections 1813, *1813a,* and 1886, be—

* * * * * * *

Payments for Emergency Hospital Services

(d)(1) Payments shall also be made to any hospital for inpatient hospital services furnished in a calendar year, by the hospital or under arrangements (as defined in section 1861(w)) with it, to an individual entitled to hospital insurance benefits under section 226 even though such hospital does not have an agreement in effect under this title if (A) such services were emergency services, (B) the Secretary would be required to make such payment if the hospital had such an agreement in effect and otherwise met the conditions of payment hereunder, and (C) such hospital has elected to claim payments for all such inpatient emergency services and for the emergency outpatient services referred to in section 1835(b) furnished during such year. Such payments shall be made only in the amounts provided under subsection (b) and then only if such hospital agrees to comply, with respect to the emergency services provided, with the provisions of section 1866(a).

(2) Payment may be made on the basis of an itemized bill to an individual entitled to hospital insurance benefits under section 226 for services described in paragraph (1) which are emergency services if (A) payment cannot be made under paragraph (1) solely because the hospital does not elect to claim such payment, and (B) such individual files application (submitted within such time and in such form and manner and by such person, and containing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement.

(3) The amounts payable under the preceding paragraph with respect to services described therein shall, subject to the provisions of [section 1813] *sections 1813 and 1813A*, be equal to 60 percent of the hospital's reasonable charges for routine services furnished in the accommodations occupied by the individual or in semiprivate accommodations (as defined in section 1861(v)(4)), whichever is less, plus 80 percent of the hospital's reasonable charges for ancillary services. If separate charges for routine and ancillary services are not made by the hospital, reimbursement may be based on two-thirds of the hospital's reasonable charges for the services received but not to exceed the charges which would have been made if the patient had occupied semiprivate accommodations. For purposes of the preceding provisions of this paragraph, the term "routine services" shall mean the regular room, dietary, and nursing services,

minor medical and surgical supplies and the use of equipment and facilities for which a separate charge is not customarily made; the term "ancillary services" shall mean those special services for which charges are customarily made in addition to routine services.

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Payment for Inpatient Hospital Services Prior to Notification of Noneligibility

(e) Notwithstanding that an individual is not entitled to have payment made under this part for inpatient hospital services furnished by any hospital, payment shall be made to such hospital (unless it elects not to receive such payment or, if payment has already been made by or on behalf of such individual, fails to refund such payment within the time specified by the Secretary) for such services which are furnished to the individual prior to notification to such hospital from the Secretary of his lack of entitlement, if such payments are precluded only by reason of section 1812 *or section 1812A* and if such hospital complies with the requirements of and regulations under this title with respect to such payments, has acted in good faith and without knowledge of such lack of entitlement, and has acted reasonably in assuming entitlement existed. Payment under the preceding sentence may not be made for services furnished an individual pursuant to any admission after the 6th elapsed day (not including as an elapsed day Saturday, Sunday, or a legal holiday) after the day on which such admission occurred.

Payment for Certain Inpatient Hospital Services Furnished Outside the United States

(f)(1) Payment shall be made for inpatient hospital services furnished to an individual entitled to hospital insurance benefits under section 226 by a hospital located outside the United States, or under arrangements (as defined in section 1861(w)) with it, if—

(A) such individual is a resident of the United States, and

(B) such hospital was closer to, or substantially more accessible from, the residence of such individual than the nearest hospital within the United States which was adequately equipped to deal with, and was available for the treatment of, such individual's illness or injury.

(2) Payment may also be made for emergency inpatient hospital services furnished to an individual entitled to hospital insurance benefits under section 226 by a hospital located outside the United States if—

(A) such individual was physically present—

(i) in a place within the United States; or

(ii) at a place within Canada while traveling without unreasonable delay by the most direct route (as determined by the Secretary) between Alaska and another State;

at the time the emergency which necessitated such inpatient hospital services occurred, and

(B) such hospital was closer to, or substantially more accessible from, such place than the nearest hospital within the

United States which was adequately equipped to deal with, and was available for the treatment of, such individual's illness or injury.

(3) Payment shall be made in the amount provided under subsection (b) to any hospital for the inpatient hospital services described in paragraph (1) or (2) furnished to an individual by the hospital or under arrangements (as defined in section 1861(w)) with it if (A) the Secretary would be required to make such payment if the hospital had an agreement in effect under this title and otherwise met the conditions of payment hereunder, (B) such hospital elects to claim such payment, and (C) such hospital agrees to comply, with respect to such services, with the provisions of section 1866(a).

(4) Payment for the inpatient hospital services described in paragraph (1) or (2) furnished to an individual entitled to hospital insurance benefits under section 226 may be made on the basis of an itemized bill to such individual if (A) payment for such services cannot be made under paragraph (3) solely because the hospital does not elect to claim such payment, and (B) such individual files application (submitted within such time and in such form and manner and by such person, and continuing and supported by such information as the Secretary shall by regulations prescribe) for reimbursement. The amount payable with respect to such services shall, subject to the provisions of [section 1813] *sections 1813 and 1813A*, be equal to the amount which would be payable under subsection (d)(3).

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FEDERAL HOSPITAL INSURANCE TRUST FUND

SEC. 1817. (a) * * *

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(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the "Board of Trustees") composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereafter in this section referred to as the "Managing Trustee"). The Administrator of the Health Care Financing Administration shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

* * * * * * *

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund. Such

report shall also include *an evaluation of the extent to which the premiums collected under sections 1839(g) and section 1839A are sufficient to pay for catastrophic coverage benefits (as defined in section 1839(g)(2)(C)(i)) and related administrative expenses payable from the Trust Fund and* an actuarial opinion by the Chief Actuarial Officer of the Health Care Financing Administration certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable. Such report shall be printed as a House document of the session of the Congress to which the report is made. A person serving on the Board of Trustees shall not be considered to be a fiduciary and shall not be personally liable for actions taken in such capacity with respect to the Trust Fund.

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PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * * * *

SCOPE OF BENEFITS

SEC. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services, except those described in subparagraphs (B) and (D) of paragraph (2); [and]

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) * * *

* * * * * * *

(F) facility services furnished in connection with surgical procedures specified by the Secretary—

* * * * * * *

and if the physician agrees to accept the standard overhead amount determined under section 1833(i)(2)(B) as full payment for such services and to accept an assignment described in section 1842(b)(3)(B)(ii) with respect to payment for all services (including all pre- and post-operative services) described in paragraphs (1) and (2)(A) of section 1861(s) and furnished in connection with such surgical procedure to individuals enrolled under this part[.]; *and*

(3) entitlement to have payment made to him or on his behalf (subject to the provisions of this title) for any catastrophic medical expenses (as defined in section 1861(ff)(1)) for a calendar year.

PAYMENT OF BENEFITS

SEC. 1833. (a) * * *

* * * * * * *

(3) in the case of services described in subparagraphs (D) and (E) of section 1832(a)(2), the costs which are reasonable and related to the cost of furnishing such services or which are based on such other tests of reasonableness as the Secretary may prescribe in regulations, including those authorized under section 1861(v)(1)(A), less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A), but in no case may the payment for such services (other than for items and services described in section 1861(s)(10)(A) and for items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2), or a third opinion, if the second opinion was in disagreement with the first opinion) exceed 80 percent of such costs; [and]

(4) in the case of facility services described in section 1832(a)(2)(F), and outpatient hospital facility services furnished in connection with surgical procedures specified by the Secretary pursuant to section 1833(i)(1)(A), the applicable amount as determined under paragraph (2) or (3) of subsection (i)[.]; *and*

(5) in the case of catastrophic medical expenses described in section 1832(a)(3), 100 percent of such expenses.

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $75; except that (1) such total amount shall not include expenses incurred for items and services described in section 1861(s)(10)(A), (2) such deductible shall not apply with respect to home health services, (3) such deductible shall not apply with respect to clinical diagnostic laboratory tests for which payment is made under this part (A) under subsection (a)(1)(D)(i) or (a)(2)(D)(i) on the basis of an assignment described in section 1842(b)(3)(B)(ii), under the procedure described in section 1870(f)(1), or to a provider having an agreement under section 1866, or (B) on the basis of a negotiated rate determined under subsection (h)(6), [and] (4) such deductible shall not apply with respect to items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion). The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed

red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence, *and (5) such deductible shall not apply with respect to the benefits described in section 1832(a)(3).*

(c) Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections [(a) and (b)] *(a), (b), and (f)* only whichever of the following amounts is the smaller:

(1) $312.50, or

(2) 62½ percent of such expenses.

* * * * * * *

(d) No payment may be made under this part with respect to any services furnished an individual to the extent that such individual is entitled (or would be entitled except for section 1813 *or section 1813A*) to have payment made with respect to such services under part A.

(e) No payment shall be made to any provider of services or other person under this part unless there has been furnished such information as may be necessary in order to determine the amounts due such provider or other person under this part for the period with respect to which the amounts are being paid or for any prior period.

(f) In applying subsection (a)(5) in the case of an organization receiving payment under clause (A) of subsection (a)(1) or under a reasonable cost reimbursement contract under section 1876 or in the case of a renal dialysis facility—

(1) the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect, in the aggregate, the aggregate increase in payments that would otherwise be made with respect to enrollees in the organization if payments were made other than under such clause or such a contract or with respect to individuals furnished services through the facility if payments were to be made on an individual-by-individual basis, and

(2) the organization or facility shall provide assurances satisfactory to the Secretary that the organization or facility will not undertake to charge an individual during a year for any catastrophic medical expenses (as defined in section 1861(ff)(1)) incurred for that year.

(g) In the case of services described in the second sentence of section 1861(p), with respect to expenses incurred in any calendar year, no more than $500 shall be considered as incurred expenses for purposes of subsections [(a) and (b)] *(a), (b) and (f).* In the case of outpatient occupational therapy services which are described in the second sentence of section 1861(p) through the operation of section 1861(g), with respect to expenses incurred in any calendar year, no more than $500 shall be considered as incurred expenses for purposes of subsections (a) and (b).

* * * * * * *

(m)(1) Not later than November 15 of each year (beginning with 1987), the Secretary shall promulgate the medicare catastrophic limit under this subsection for the succeeding year.

(2) The medicare catastrophic limit for 1988 is $1,700. The medicare catastrophic limit for any succeeding year shall be an amount equal to the medicare catastrophic limit for the preceding year increased by the applicable increase percentage determined under section 215(i) in the previous year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

SEC. 1835. (a) * * *

* * * * * * *

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes a certification of the kind provided in subparagraph (A) or (B) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary). For purposes of the preceding sentence, service by a physician as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency. *For purposes of paragraph (2)(C), an individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker) or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home", the condition of the individual should be such that there exists a normal inability to leave home, that leaving home requires a considerable and taxing effort by the individual, and that absences of the individual from home are infrequent or of relatively short duration.*

* * * * * * *

AMOUNTS OF PREMIUMS

SEC. 1839. (a)(1) [The Secretary shall, during September of 1983 and of each year thereafter, determine the monthly actuarial rate for enrollees age 65 and over which shall be applicable for the succeeding calendar year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to those enrollees age 65 and older will equal one-half of the total of the benefit and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees. In calculating the monthly actuarial rate, the Secretary shall include an appropriate amount for a contingency margin.] *(A) The Secretary shall, during September of 1987 and of each year thereafter, determine the monthly actuarial basic rate for enrollees age 65 and over which shall be applicable for the succeeding calendar year. The monthly actuarial basic rate determined under this paragraph for a calendar year shall be the amount the Secretary estimates to be necessary so that the aggregate amount for the calendar year with respect to those enrollees age 65 and over will equal one-half of the total of the benefits and administrative costs that the Secretary estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees (excluding catastrophic coverage benefits and related administrative costs). In calculating the monthly actuarial basic rate, the Secretary shall include an appropriate amount for a contingency margin.*

(B) For purposes of this paragraph, the term "catastrophic coverage benefits" has the meaning given to such term in subsection (g)(2)(C)(i).

* * * * * * *

(3) The Secretary shall, during September of 1983 and of each year thereafter, determine and promulgate the monthly premium applicable for individuals enrolled under this part for the succeeding calendar year. The monthly premium shall (except as otherwise provided in [subsection (e)] *subsections (e) and (g)*) be equal to the smaller of—

* * * * * * *

[(4) The Secretary shall also, during September of 1983 and of each year thereafter, determine the monthly actuarial rate for disabled enrollees under age 65 which shall be applicable for the succeeding calendar year. Such actuarial rate shall be the amount the Secretary estimates to be necessary so that the aggregate amount for such calendar year with respect to disabled enrollees under age 65 which will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees. In calculating the monthly actuarial rate under this paragraph, the Secretary shall include an appropriate amount for a contingency margin.]

(4)(A) The Secretary shall also, during September of 1987 and of each year thereafter, determine the monthly actuarial basic rate for disabled enrollees under age 65 which shall be applicable for the succeeding calendar year. The monthly actuarial basic rate determined under this paragraph for a calendar year shall be the amount the Secretary estimates to be necessary so that the aggregate amount for the calendar year with respect to disabled enrollees under age 65 will equal one-half of the total of the benefits and administrative costs which he estimates will be payable from the Federal Supplementary Medical Insurance Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees (excluding catastrophic coverage benefits and related administrative costs). In calculating the monthly actuarial basic rate under this paragraph, the Secretary shall include an appropriate amount for a contingency margin.

(B) For purposes of this paragraph, the term "catastrophic coverage benefits" has the meaning given to such term in subsection (g)(2)(C)(i).

* * * * * * *

(e)(1) Notwithstanding the provisions of subsection (a), the monthly premium for each individual enrolled under this part for each month after December 1983 and prior to January 1989 shall be an amount equal to 50 percent of the monthly actuarial *basic* rate for enrollees age 65 and over, as determined under subsection (a)(1) and applicable to such month.

* * * * * * *

(g)(1) Notwithstanding any other provision of this section, except as provided in paragraph (3), the monthly premium otherwise determined under this section for an individual for each month in calendar year 1988 after March, and for every month in any succeeding calendar year shall be increased by an amount equal to the applicable monthly catastrophic coverage premium amount for that year.

(2)(A)(i) The monthly catastrophic coverage premium amount for 1988 for individuals who are covered by the insurance programs under part A and this part shall be $4. The monthly catastrophic coverage premium amount for such individuals for any succeeding calendar year shall be the monthly catastrophic coverage premium amount determined under this subparagraph for the preceding calendar year, increased (or decreased) by the percentage increase (or decrease) in the per enrollee actuarial comprehensive catastrophic benefit amount for the year for which the determination is made over the per enrollee actuarial comprehensive catastrophic benefit amount for such preceding year. For purposes the preceding sentence, in determining the percentage increase (or decrease) in the per enrollee actuarial comprehensive catastrophic benefit amount for calendar year 1989 over the per enrollee actuarial comprehensive catastrophic benefit amount for calendar year 1988, the total of the catastrophic coverage benefits (and related administrative costs) payable with respect to enrollees under this part in calendar year 1988 shall be computed as if the medical catastrophic limit under section 1833(m) applied to out-of-pocket medical expenses incurred for the entire calendar year. For any calendar year beginning after

1992, the Secretary shall adjust the monthly catastrophic coverage premium amount by the percentage determined under section 1839A(b)(2)(B)(ii)(iv).

(ii) The monthly catastrophic coverage premium amount for any calendar year for individuals who are covered by the insurance program under this part but not by the insurance program under part A shall be an amount that bears the same ratio to the monthly catastrophic coverage premium amount determined under clause (i) for such year as the actuarial part B catastrophic benefit amount for such year bears to the actuarial comprehensive catastrophic benefit amount for such year.

(B) If any monthly premium amount determined under subparagraph (A) is not a multiple of 10 cents, such premium amount shall be rounded to the nearest multiple of 10 cents.

(C) For purposes of this paragraph—

(i) the term "catastrophic coverage benefits" means benefits payable under this title by reason of the enactment of the amendments made by sections 2(a), 3(a), 4, and 7(b) of the Medicare Catastrophic Loss Prevention Act of 1987,

(ii) the term "per enrollee actuarial comprehensive catastrophic benefit amount" means, with respect to a year, an amount equal to the actuarial comprehensive catastrophic benefit amount for the year divided by the total number of individuals that the Secretary estimates will be enrolled under this part for the year,

(iii) the term "actuarial comprehensive catastrophic benefit amount" means, with respect to a calendar year, the amount that the Secretary estimates will equal the total of the catastrophic coverage benefits (and related administrative costs) that will be payable from the Federal Supplementary Medical Insurance Trust Fund and from the Federal Hospital Insurance Trust Fund in such calendar year with respect to enrollees under this part, and

(iv) the term "actuarial part B catastrophic benefit amount" means, with respect to a calendar year, the amount the Secretary estimates will equal the total of the catastrophic coverage benefits (and related administrative costs) that will be payable from the Federal Supplementary Medical Insurance Trust Fund in such calendar year with respect to such enrollees (excluding any amounts transferred pursuant to section 1841(j)).

(3) For any calendar year after 1988, if an individual is entitled to monthly benefits under section 202 or 223 for November and December of the preceding year, and if the monthly premium of the individual under this section for December and for January is deducted from those benefits under section 1840(a)(1), the monthly premium otherwise determined under this section for an individual for that year shall not be increased, pursuant to paragraph (1), to the extent that such increase would reduce the amount of benefits payable to that individual for that January below the amount of benefits payable to that individual for that December (after the deduction of the premium under this section).

SUPPLEMENTAL PREMIUM FOR INDIVIDUALS COVERED BY PART B

SEC. 1839A. (a)(1) Any individual described in paragraph (2) shall pay the applicable supplemental premium in the manner provided in subsection (c).

(2) An individual is described in this paragraph if such individual—

(A) is covered by the insurance program established under this part for any portion of any taxable year occurring after December 31, 1987, and

(B) has Federal income tax liability for such taxable year in an amount not less than $150.

(b) For purposes of this section—

(1) The term "applicable supplemental premium" means an amount equal to the product of—

(A) the number of months in the taxable year during which the individual was covered by the insurance program established under this part, multiplied by

(B) the supplemental premium.

(2)(A) The term "supplemental premium" means an amount equal to the product of—

(i) the premium rate for the taxable year, multiplied by

(ii) the amount determined by dividing—

(I) the individual's Federal income tax liability for such taxable year, by

(II) $150.

If any amount determined under clause (ii) is not a whole number, such amount shall be rounded to the next lowest whole number.

(B)(i) The premium rate for any taxable year beginning before 1989 is $1.02. The premium rate for any taxable year beginning in a calendar year after 1988 is the premium rate determined under this clause for taxable years beginning in the preceding calendar year, increased or decreased by the premium rate adjustment under clause (ii) for taxable years beginning in the calendar year for which the determination is made.

(ii)(I) For purposes of clause (i), the premium rate adjustment for taxable years beginning in a calendar year after 1988 is the percentage increase or decrease in the per enrollee actuarial comprehensive catastrophic benefit amount (within the meaning of section 1839(g)(2)(C)(ii)) for such calendar year over such amount for the preceding calendar year.

(II) The Secretary shall adjust the premium rate for any calendar year beginning after 1992 (without regard to this subclause and subclause (IV)) to appropriately reflect any percentage increase or decrease in the estimated average Federal income tax liability of individuals described in subsection (a)(2) for such calendar year over such average for the preceding calendar year.

(III) In determining the percentage increase (or decrease) under subclause (I) for calendar year 1989, the total of the catastrophic coverage benefits (within the meaning of section 1839(g)(2)(C)(i)) (and related administrative costs) payable with respect to enrollees under this part in calendar year 1988 shall

be computed as if the medicare catastrophic limit under section 1833(m) applied to out-of-pocket medical expenses incurred for the entire calendar year.

(IV) If the Secretary determines for any calendar year beginning after 1992 that the estimated total catastrophic coverage benefits (within the meaning of section 1839(g)(2)(C)(i)) and related administrative costs for such calendar year will exceed the estimated total revenues collectable with respect to such calendar year from the premiums under this section and the monthly catastrophic coverage premiums (within the meaning of section 1839(g)(2)(A)), the Secretary shall increase the premium rate under this section and the monthly catastrophic coverage premium for such calendar year by the percentage necessary to increase the estimated total revenues for such calendar year by the amount of such excess.

(3)(A)(i) In the case of a taxable year beginning in a calendar year after 1987 and before 1993, the applicable supplemental premimum for any individual shall not exceed the amount which bears the same ratio to the amount determined under the table in clause (ii) as—

(I) the number of months determined under paragraph (1)(A), bears to

(II) 12.

(ii) For purposes of clause (i)—

If the taxable year begins in:	*The amount is:*
1988	*$800*
1989	*850*
1990	*900*
1991	*950*
1992	*1,000.*

(B) In the case of a taxable year beginning in a calendar year after 1992, the applicable supplemental premium for any individual shall not exceed an amount equal to 65 percent of the product of—

(i) the number of months determined under paragraph (1)(A), multiplied by

(ii) the excess of—

(I) the sum of 200 percent of the monthly actuarial basic rate for enrollees age 65 or over (as determined under section 1839), and the monthly per enrollee actuarial comprehensive catastrophic benefit amount for such calendar year, over

(II) the sum of the basic and catastrophic monthly premiums for such year (as determined under section 1839 without regard to subsections (f)(2) and (g)(3) thereof).

(4)(A) Except as provided in this paragraph, in the case of married individuals (within the meaning of section 7703 of the Internal Revenue Code of 1986)—

(i) who file a joint return under section 6013 of such Code, and

(ii) 1 or both of whom are described in subsection (a)(2) with respect to such taxable year,

the applicable supplemental premiums shall be determined by treating such individuals as 1 individual.

(B) If subparagraph (A) applies, the number of months taken into account under paragraph (1)(A) (other than for purposes of paragraph (3)) shall be determined by reference to the spouse who was covered by the insurance program established under this part for the longer period during the taxable year (or if covered for the same period, either spouse).

(C) If subparagraph (A) applies and both spouses are covered during the taxable year by the insurance program established under this part, the limitation under paragraph (3) shall be equal to the sum of the limitations computed separately under paragraph (3) for each of the spouses.

(c)(1) Except as provided in paragraph (2), for purposes of the Internal Revenue Code of 1986 (other than section 15 of such Code), any applicable supplemental premium required to be paid under subsection (a)(1) shall be treated as an addition to the tax imposed by chapter 1 of such Code for the taxable year to which such premium relates.

(2) Any applicable supplemental premium required to be paid under subsection (a)(1) shall not be treated as an addition to the tax imposed by chapter 1 of the Internal Revenue Code of 1986 for purposes of determining—

(A) the amount of any credit allowable under such chapter, or

(B) the amount of the minimum tax imposed by section 55 of such Code.

(d)(1) For purposes of this section, the term "Federal income tax liability" means—

(A) the tax imposed by chapter 1 of the Internal Revenue Code of 1986 (without regard to this section), reduced by

(B) the amount of the credits allowed under part IV of subchapter A of such chapter (other than sections 31, 33, and 34).

(2) For purposes of section 213(d)(1)(C) of the Internal Revenue Code of 1986, the applicable supplemental premium under subsection (a)(1) shall be treated as a premium paid under this part in the taxable year following the taxable year to which such premium relates.

(e) The Secretary of the Treasury shall, from time to time, transfer from the general fund of the Treasury to the Federal Supplementary Medical Insurance Trust Fund amounts equal to the sum of—

(1) the aggregate monthly supplemental premiums paid pursuant to this section, plus

(2) the amount which the Secretary estimates Federal outlays are reduced under title XIX of this Act by reason of the amendments made by sections 2(a), 3(a), 4, and 7(b) of the Medicare Catastrophic Loss Prevention Act of 1987 (after taking into account the provisions of section 14 of such Act).

Such transfer shall be appropriately adjusted to the extent that prior transfers were in excess of or less than the amounts required to be transferred.

PAYMENT OF PREMIUMS

SEC. 1840. (a)(1) In the case of an individual who is entitled to monthly benefits under section 202 or 223, his monthly premiums under this part shall [except as provided in subsections (b)(1) and (c))] *(except as provided in section 1839A(a)(2) and subsections (b)(1) and (c) of this section)* be collected by deducting the amount thereof from the amount of such monthly benefits. Such deduction shall be made in such manner and at such times as the Secretary shall by regulation prescribe.

* * * * * * *

FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

SEC. 1841. (a) * * *

* * * * * * *

(b) With respect to the Trust Fund, there is hereby created a body to be known as the Board of Trustees of the Trust Fund (hereinafter in this section referred to as the "Board of Trustees") composed of the Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health and Human Services, all ex officio, and of two members of the public (both of whom may not be from the same political party), who shall be nominated by the President for a term of four years and subject to confirmation by the Senate. The Secretary of the Treasury shall be the Managing Trustee of the Board of Trustees (hereinafter in this section referred to as the "Managing Trustee"). The Administrator of the Health Care Financing Administration shall serve as the Secretary of the Board of Trustees. The Board of Trustees shall meet not less frequently than once each calendar year. It shall be the duty of the Board of Trustees to—

* * * * * * *

The report provided for in paragraph (2) shall include a statement of the assets of, and the disbursements made from, the Trust Fund during the preceding fiscal year, an estimate of the expected income to, and disbursements to be made from, the Trust Fund during the current fiscal year and each of the next 2 fiscal years, and a statement of the actuarial status of the Trust Fund. Such report shall also include *an evaluation of the extent to which the premiums collected under sections 1839(g) and section 1839A are sufficient to pay for catastrophic coverage benefits (as defined in section 1839(g)(2)(C)(i)) and related administrative expenses payable from the Trust Fund and* an actuarial opinion by the Chief Actuarial Officer of the Health Care Financing Administration certifying that the techniques and methodologies used are generally accepted within the actuarial profession and that the assumptions and cost estimates used are reasonable. Such report shall be printed as a House document of the session of the Congress to which the report is made.

* * * * * * *

(j) There shall be transferred from time to time from the Trust Fund to the Federal Hospital Insurance Trust Fund amounts from

the premiums under this part that are attributable to the changes (under sections 2(a), 3(a), and 7(b) of the Medicare Catastrophic Loss Prevention Act of 1987) in services performed and related administrative costs incurred in such calendar year with respect to individuals who are covered under the insurance program established by part A.

PART C—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) The term "spell of illness" with respect to any individual means a period of consecutive days—

* * * * * * *

Home Health Services

(m) The term "home health services" means the following items and services furnished to an individual, who is under the care of a physician, by a home health agency or by others under arrangements with them made by such agency, under a plan (for furnishing such items and services to such individual) established and periodically reviewed by a physician, which items and services are, except as provided in paragraph (7), provided on a visiting basis in a place of residence used as such individual's home—

(1) * * *

* * * * * * *

excluding, however, any item or service if it would not be included under subsection (b) if furnished to an inpatient of a hospital. *For purposes of paragraphs (1) and (4), nursing care and home health aide services may be provided under such paragraphs seven days a week (with one or more visits per day) for a period of up to 21 days with a physician's certification of the need for such care and services on such a basis. In the case of an individual who is covered under the insurance program established under part B, and who is furnished nursing care and home health aide services within 30 days after being discharged from a hospital or a skilled nursing facility, the preceding sentence shall be applied by substituting "45 days" for "21 days".*

* * * * * * *

Reasonable Cost

(v)(1)(A) * * *

* * * * * * *

(G)(i) In any case in which a hospital provides inpatient services to an individual that would constitute **[**post-hospital extended care services**]** *extended care services or post-hospital extended care services* if provided by a skilled nursing facility and a quality control and peer review organization (or, in the absence of such a qualified

organization, the Secretary or such agent as the Secretary may designate) determines that inpatient hospital services for the individual are not medically necessary but [post-hospital extended care services] *extended care services or post-hospital extended care services* for the individual are medically necessary [and such extended care services] *and such services* are not otherwise available to the individual (as determined in accordance with criteria established by the Secretary) at the time of such determination, payment for such services provided to the individual shall continue to be made under this title at the payment rate described in clause (ii) during the period in which—

(I) such [post-hospital extended care services] *extended care services or post-hospital extended care services* for the individual are medically necessary and not otherwise available to the individual (as so determined),

(II) inpatient hospital services for the individual are not medically necessary, and

(III) the individual is entitled to have payment made for [post-hospital extended care services] *extended care services or post-hospital extended care services* under this title,

except that if the Secretary determines that there is not an excess of hospital beds in such hospital and (subject to clause (iv)) there is not an excess of hospital beds in the area of such hospital, such payment shall be made (during such period) on the basis of the amount otherwise payable under part A with respect to inpatient hospital services.

* * * * * * *

(2)(A) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services), *extended care services,* or post-hospital extended care services is in accommodations more expensive than semi-private accommodations, the amount taken into account for purposes of payment under this title with respect to such services may not exceed the amount that would be taken into account with respect to such services if furnished in such semi-private accommodations unless the more expensive accommodations were required for medical reasons.

(B) Where a provider of services which has an agreement in effect under this title furnishes to an individual items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under part A or part B, as the case may be, the Secretary shall take into account for purposes of payment to such provider of services only the items or services with respect to which such payment may be made.

(3) If the bed and board furnished as part of inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services), *extended care services,* or post-hospital extended care services is in accommodations other than, but not more expensive than, semi-private accommodations and the use of such other accommodations rather than semi-private accommodations was neither at the request of the patient nor for a reason which the Secretary determines is consistent with the purposes of this title, the amount of the payment with respect to such

bed and board under part A shall be the amount otherwise payable under this title for such bed and board furnished in semi-private accommodations minus the difference between the charge customarily made by the hospital or skilled nursing facility for bed and board in semi-private accommodations and the charge customarily made by it for bed and board in the accommodations furnished.

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Post-Hospital Extended Care in Christian Science Skilled Nursing Facilities

(y)(1) * * *

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[(2) Notwithstanding any other provision of this title, payment under part A may not be made for services furnished an individual in a skilled nursing facility to which paragraph (1) applies unless such individual elects, in accordance with regulations, for a spell of illness to have such services treated as post-hospital extended care services for purposes of such part; and payment under part A may not be made for post-hospital extended care services—

[(A) furnished an individual during such spell of illness in a skilled nursing facility to which paragraph (1) applies after—

[(i) such services have been furnished to him in such a facility for 30 days during such spell, or

[(ii) such services have been furnished to him during such spell in a skilled nursing facility to which such paragraph does not apply; or

[(B) furnished an individual during such spell of illness in a skilled nursing facility to which paragraph (1) does not apply after such services have been furnished to him during such spell in a skilled nursing facility to which such paragraph applies.

[(3) The amount payable under part A for post-hospital extended care services furnished an individual during any spell of illness in a skilled nursing facility to which paragraph (1) applies shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day before the 31st day on which he is furnished such services in such a facility during such spell (and the reduction under this paragraph shall be in lieu of any reduction under section 1813 (a)(3)).]

(2)(A) Notwithstanding any other provision of this title, payment may not be made under part A for services furnished to an individual who is covered by the insurance programs under such part and part B in a skilled nursing facility to which paragraph (1) applies unless such individual elects, in accordance with regulations, for a calendar year to have such services treated as extended care services for purposes of such part; and payment under part A may not be made for extended care services—

(i) furnished to an individual during such year in a skilled nursing facility to which paragraph (1) applies after—

(I) such services have been furnished to him in such a facility for 30 days during such year, or

(II) such services have been furnished to him during such year in a skilled nursing facility to which such paragraph does not apply; or

(ii) furnished to an individual during such year in a skilled nursing facility to which paragraph (1) does not apply after such services have been furnished to him during such year in a skilled nursing facility to which such paragraph applies.

(B) In the case of an individual who is covered by the insurance program under part A but not by the insurance program under part B, the provisions of subparagraph (A) shall be applied by substituting "spell of illness" for "calendar year", by substituting "spell" for "year" each place it appears, and by substituting "post-hospital extended care services" for "extended care services" each place it appears.

(3)(A) The amount payable under part A for extended care services furnished during any calendar year in a skilled nursing facility to which paragraph (1) applies to an individual who is covered by the insurance programs established under such part and part B shall be reduced by a coinsurance amount equal to the coinsurance amount established under section 1813(a)(3)(C) for each day before the 10th day.

(B)(i) The amount payable under part A for post-hospital extended care services furnished during any calendar year to an individual who is covered by the insurance program established under such part but not by the insurance program established under part B in a skilled nursing facility to which paragraph (1) applies shall be reduced by a coinsurance amount equal to one-eighth of the inpatient hospital deductible for each day before the 31st day on which the individual is furnished such services in a facility during such spell (and the reduction under this paragraph shall be in lieu of any reduction under section 1813A(a)(3).

(ii) For purposes of this subparagraph—

(I) the "inpatient hospital deductible" for a year is the inpatient hospital deductible promulgated under section 1813 for that year, and

(II) the inpatient hospital deductible for a year shall apply to the coinsurance amounts under clause (i) for post-hospital extended care services furnished in that year.

* * * * * * *

Hospice Care; Hospice Program

(dd)(1) * * *

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(2) The term "hospice program" means a public agency or private organization (or a subdivision thereof) which—

(A)(i) * * *

* * * * * * *

(iii) provides assurances satisfactory to the Secretary that the aggregate number of days of inpatient care described in paragraph (1)(G) provided in any 12-month period to individuals who have an election in effect under section [1812(d)]

1812(c) with respect to that agency or organization does not exceed 20 percent of the aggregate number of days during that period on which such elections for such individuals are in effect;

* * * * * * *

(ff)(1) The term "catastrophic medical expenses" means, with respect to an individual for a calendar year (beginning with 1988), any beneficiary cost sharing amounts (as defined in paragraph (2)) incurred by an individual in the year after the individual has incurred out-of-pocket medical expenses (as defined in paragraph (3)) in the year in an amount equal to the medicare catastrophic limit established under section 1833(m) for the year.

(2) The term "beneficiary cost sharing amounts" means the amounts of expenses that an individual who is covered by the insurance program established under part B incurs that are attributable to—

(A) the deductions and coinsurance amounts established under section 1813(a) and under subsection (y)(3),

(B) the deductions established under section 1833(b), or

(C) the difference between the payment amount provided under part B and the payment amount that would be provided if "100 percent" and "0 percent" were substituted for "80 percent" and "20 percent", respectively, each place either appears in section 1833(a), in section 1833(i)(2), in section 1835(b)(2), and in subsections (b)(2) and (b)(3) of section 1881.

(3) The term "out-of-pocket medical expenses" means the amounts expended by an individual who is covered under the insurance program established under part B that are—

(A) beneficiary cost sharing amounts,

(B) amounts expended by an individual described in subsection (s)(2)(J) for immunosuppressive drugs furnished after the 1-year period specified in such subsection (in amounts not to exceed the reasonable charges for such drugs), and

(C) amounts expended for qualified examinations for the early detection of cancer (in amounts not to exceed the reasonable charges for such examinations).

(4) An examination that is performed with respect to an individual covered by the insurance program under part B shall be treated as a "qualified examination for the early detection of cancer" if the examination is—

(A) a routine mammogram for the purpose of the diagnosis of breast cancer that is performed with respect to an individual who—

(i) has attained age 55, and

(ii) has not had a mammogram on a routine basis during the preceding 36 months; or

(B) a routine colorectal examination for the purpose of the diagnosis of colorectal cancer that is performed with respect to an individual who—

(i) has attained age 65, and

(ii) has not had a colorectal examination on a routine basis during the preceding 12 months.

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) * * *

* * * * * * *

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section [1813 (a)(1), (a)(3), or (a)(4)] *paragraph (1), (3), or (4) of section 1813, paragraph (1) or (3) of section 1813A*, section 1833(b), or section 1861(y)(3) with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider), and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B (but in the case of items and services furnished to individuals with end-stage renal disease, an amount equal to 20 percent of the estimated amounts for such items and services calculated on the basis established by the Secretary). In the case of items and services described in section 1833(c), clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section. A provider of services may not impose a charge under clause (ii) of the first sentence of this subparagraph with respect to items and services described in section 1861(s)(10)(A), with respect to items and services furnished in connection with obtaining a second opinion required under section 1164(c)(2) (or a third opinion, if the second opinion was in disagreement with the first opinion), and with respect to clinical diagnostic laboratory tests for which payment is made under part B or which are durable medical equipment furnished as home health services. *A provider of services may not impose a charge under the first sentence of this subparagraph for services for which payment is made to the provider pursuant to section 1833(a)(5) (relating to catastrophic medical expenses).*

* * * * * * *

(C) A provider of services may in accordance with its customary practice also appropriately charge any such individual for any whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished him with respect to which a deductible is imposed under section 1813(a)(2) *or section 1813A(a)(2)*, except that (i) any excess of such charge over the cost to such provider for the blood (or equivalent quantities of packed red blood cells, as so defined) shall be deducted from any payment to such provider under this title, (ii) no such charge may be imposed for the cost of administration of such blood (or equivalent quantities of packed red blood cells, as so defined), and (iii) such charge may not be made to the extent such blood (or equivalent quantities of packed red blood cells, as so defined) has been replaced on behalf of such individual or arrangements have been made for its replacement on his behalf. For purposes of subparagraph (C), whole blood (or equivalent quantities of packed red blood cells, as so defined) furnished an individual shall be deemed replaced when the provider of services is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) fur-

nished such individual with respect to which a deduction is imposed under section 1813(a)(2) *or section 1813A(a)(2).*

* * * * * * *

(b) An agreement with the Secretary under this section may be terminated—

(1) * * *

* * * * * * *

Any termination shall be applicable—

(3) in the case of inpatient hospital services (including inpatient psychiatric hosptial services), *extended care services,* or post-hospital extended care services, with respect to services furnished after the effective date of such termination, except that payment may be made for up to thirty days with respect to inpatient institutional services furnished to any eligible individual who was admitted to such institution prior to the effective date of such termination,

* * * * * * *

(d) If the Secretary finds that there is a substantial failure to make timely review in accordance with section 186(k) of long-stay cases in a hospital or skilled nursing facility, he may, in lieu of terminating his agreement with such hospital or facility, decide that, with respect to any individual admitted to such hospital or facility after a subsequent date specified by him, no payment shall be made under this title for inpatient hospital services (including inpatient psychiatric hospital services) after the 20th day of a continuous period of such services or for *extended care services or* post-hospital extended care services after such day of a continuous period of such care as is prescribed in or pursuant to regulations, as the case may be. Such decision may be made effective only after such notice to the hospital, or (in the case of a skilled nursing facility) to the facility and the hospital or hospitals with which it has a transfer agreement, and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the Secretary finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur. The Secretary shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

VOLUNTARY CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES

SEC. 1882. (a) The Secretary shall establish a procedure whereby medicare supplemental policies (as defined in subsection (g)(1)) may be certified by the Secretary as meeting minimum standards and requirements set forth in subsection (c). Such procedure shall provide an opportunity for any insurer to submit any such policy, and such additional data as the Secretary finds necessary, to the Secretary for his examination and for his certification thereof as meeting the standards and requirements set forth in subsection (c). [Such certification] *Subject to subsection (k)(3), such certification* shall remain in effect if the insurer files a notarized statement with the Secretary no later than June 30 of each year stating that the policy continues to meet such standards and requirements and

if the insurer submits such additional data as the Secretary finds necessary to independently verify the accuracy of such notarized statement. Where the Secretary determines such a policy meets (or continues to meet) such standards and requirements, he shall authorize the insurer to have printed on such policy (but only in accordance with such requirements and conditions as the Secretary may prescribe) an emblem which the Secretary shall cause to be designed for use as an indication that a policy has received the Secretary's certification. The Secretary shall provide each State commissioner or superintendent of insurance with a list of all the policies which have received his certification.

(b)(1) Any medicare supplemental policy issued in any State which the Supplemental Health Insurance Panel (established under paragraph (2)) determines has established under State law a regulatory program that—

(A) provides for the application of standards with respect to such policies equal to or more stringent than the NAIC Model Standards (as defined in subsection (g)(2)(A));

[(B) includes a requirement equal to or more stringent than the requirement described in subsection (c)(2); and]

(B) includes requirements equal to or more stringent than the requirements described in paragraphs (2) and (3) of subsection (c);

(C) provides that—

(i) information with respect to the actual ratio of benefits provided to premiums collected under such policies will be reported to the State on forms conforming to those developed by the National Association of Insurance Commissioners for such purpose, or

(ii) such ratios will be monitored under the program in an alternative manner approved by the Secretary; and

[(C)]*(D)* provides for application of the standards and requirements described in subparagraphs [(A) and (B)] *(A), (B), and (C)* to all medicare supplemental policies (as defined in subsection (g)(1)) issued in such State,

shall be deemed [(for so long as] *(subject to subsection (k)(3), for so long as* the Panel finds that such State regulatory program continues to meet the standards and requirements of this paragraph) to meet the standards and requirements set forth in subsection (c).

* * * * * * *

(c) The Secretary shall certify under this section any medicare supplemental policy, or continue certification of such a policy, only if he finds that such policy—

(1) meets or exceeds (either in a single policy or, in the case of nonprofit hospital and medical service associations, in one or more policies issued in conjunction with one another) the NAIC Model Standards; [and]

(2) can be expected (as estimated for the entire period for which rates are computed to provide coverage, on the basis of incurred claims experience and earned premiums for such period and in accordance with accepted actuarial principles and practices) to return to policyholders in the form of aggregate benefits provided under the policy, at least 75 percent of

the aggregate amount of premiums collected in the case of group policies and at least 60 percent of the aggregate amount of premiums collected in the case of individual policies[.], *and*

(3) may, during a period of not less than 30 days after the policy is issued, be returned for a full refund of any premiums paid (without regard to the manner in which the purchase of the policy was solicited).

* * * * * * *

(e)*(1)* The Secretary shall provide to all individuals entitled to benefits under this title (and, to the extent feasible, to individuals about to become so entitled) such information as will permit such individuals to evaluate the value of medicare supplemental policies to them and the relationship of any such policies to benefits provided under this title.

(2) The Secretary shall—

(A) inform all individuals entitled to benefits under this title (and, to the extent feasible, individuals about to become so entitled) of—

(i) the actions and practices that are subject to sanctions under subsection (d), and

(ii) the manner in which they may report any such action or practice to an appropriate official of the Department of Health and Human Services, and

(B) establish a toll-free telephone number for individuals to report suspected violations of the provisions of such subsection.

(3) The Secretary shall provide individuals entitled to benefits under this title (and, to the extent feasible, individuals about to become so entitled) with a listing of the addresses and telephone numbers of State and Federal agencies and offices that provide information and assistance to individuals with respect to the selection of medicare supplemental policies.

* * * * * * *

(k)(1)(A) If, within the period specified in subparagraph (B), the National Association of Insurance Commissioners (in this subsection referred to as the "Association") amends the NAIC Model Regulation adopted on June 6, 1979 (as it relates to medicare supplemental policies), to reflect the changes in law made by the Medicare Catastrophic Loss Prevention Act of 1987, subsection (g)(2)(A) shall be applied, effective on and after the date specified in subparagraph (C), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the Model Regulation as amended by the Association in accordance with this paragraph (in this subsection referred to as the "amended NAIC Model Regulation").

(B) The period specified in this subparagraph is the period beginning on the date of the enactment of the Medicare Catastrophic Loss Prevention Act of 1987 and ending on the ninetieth day after such date.

(C) The date specified in this subparagraph is the date that is 365 days after the date (within the period specified in subparagraph (B)) on which the National Association of Insurance Commissioners announces the adoption of the amendments referred to in subparagraph (A).

(2)(A) If the Association does not amend the NAIC Model Regulation referred to in subsection (g)(2)(A) during the period specified in paragraph (1)(B), the Secretary shall issue Federal model standards (in this subsection referred to as "Federal model standards") for medicare supplemental policies not later than 90 days after the last day of such period. Federal model standards issued by the Secretary pursuant to this subparagraph shall reflect the changes in law made by the Medicare Catastrophic Loss Prevention Act of 1987.

(B) Effective on and after the date that is 365 days after the date on which the Secretary issues Federal model standards pursuant to subparagraph (A), this section shall be applied as if any reference to NAIC Model Standards were a reference to the Federal model standards.

(3) Notwithstanding any other provision of this section, on and after the date specified in paragraph (1)(C) or the date specified in paragraph (2)(B) (as the case may be)—

(A) no medicare supplemental policy may be certified by the Secretary pursuant to subsection (a),

(B) no certification made pursuant to subsection (a) shall remain in effect, and

(C) no State regulatory program shall be found to meet (or to continue to meet) the requirements of subsection (b)(1),

unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set forth in the amended NAIC Model Regulation or the Federal model standards (as the case may be).

HOSPITAL PROVIDERS OF EXTENDED CARE SERVICES

SEC. 1883. (a)(1) * * *

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(d) Any agreement with a hospital under this section shall provide that payment for services will be made only for services for which payment would be made as [post-hospital extended care services] *extended care services or post-hospital extended care services* if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1866; and any individual who is furnished services, for which payment may be made under an agreement under this section, shall, for purposes of this title (other than this section), be deemed to have received [post-hospital extended care services] *extended care services or post-hospital extended care services* in like manner and to the same extent as if the services furnished to him had been [post-hospital extended care services] *extended care services or post-hospital extended care services* furnished by a skilled nursing facility under an agreement under section 1866.

* * * * * * *

(f) A hospital which enters into an agreement with the Secretary under this section shall be required to meet those conditions applicable to skilled nursing facilities relating to discharge planning and the social services function (and staffing requirements to satisfy it) which are promulgated by the Secretary under section 1861(j)(15). Services furnished by such a hospital which would oth-

erwise constitute [post-hospital extended care services] *extended care services or post-hospital extended care services* if furnished by a skilled nursing facility shall be subject to the same requirements applicable to such services when furnished by a skilled nursing facility except for those requirements the Secretary determines are inappropriate in the case of these services being furnished by a hospital under this section.

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PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES

SEC. 1886. (a)(1)(A)(i) * * *

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(b)(1) Nothwithstanding section 1814(b) but subject to the provisions of [section 1813] *sections 1813 and 1813A*, if the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a hospital (other than a subsection (d) hospital, as defined in subsection (d)(1)(B)) for a cost reporting period subject to this paragraph—

(A) are less than or equal to the target amount (as defined in paragraph (3)) for that hospital for that period, the amount of the payment with respect to such operating costs payable under part A on a per discharge or per admission basis (as the case may be) shall be equal to the amount of such operating costs, plus—

(i) 50 percent of the amount by which the target amount exceeds the amount of the operating costs, or

(ii) 5 percent of the target amount,

whichever is less; or

(B) are greater than the target amount, the amount of the payment with respect to such operating costs payable under part A on a per discharge or per admission basis (as the case may be) shall be equal to (i) the target amount, plus (ii) in the case of cost reporting periods beginning on or after October 1, 1982, and before October 1, 1984, 25 percent of the amount by which the amount of the operating costs exceeds the target amount;

except that in no case may the amount payable under this title (other than on the basis of a DRG prospective payment rate determined under subsection (d)) with respect to operating costs of inpatient hospital services exceed the maximum amount payable with respect to such costs pursuant to subsection (a).

* * * * * * *

(d)(1)(A) Notwithstanding section 1814(b) but subject to the provisions of [section 1813] *sections 1813 and 1813A*, the amount of the payment with respect to the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a subsection (d) hospital (as defined in subparagraph (B)) for inpatient hospital discharges in a cost reporting period or in a fiscal year—

(i) beginning on or after October 1, 1983, and before October 1, 1984, is equal to the sum of—

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting

period (as defined in subsection (b)(3)(A), but determined without the application of subsection (a)), and

(II) the DRG percentage (as defined in subparagraph (C)) of the regional adjusted DRG prospective payment rate determined under paragraph (2) for such discharges;

(ii) beginning on or after October 1, 1984, and before October 1, 1987, is equal to the sum of—

(I) the target percentage (as defined in subparagraph (C)) of the hospital's target amount for the cost reporting period (as defined in subsection (b)(3)(A), but determined without the application of subsection (a)), and

(II) the DRG percentage (as defined in subparagraph (C)) of the applicable combined adjusted DRG prospective payment rate determined under subparagraph (D) for such discharges; or

(iii) beginning on or after October 1, 1987, is equal to the national adjusted DRG prospective payment rate determined under paragraph (3) for such discharges.

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TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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PAYMENT TO STATES

SEC. 1903. (a) * * *

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(g)(1) Subject to paragraph (3), with respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1876 or which is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act)), the Federal medical assistance percentage shall be decreased as follows: After an individual has received inpatient hospital services or intermediate care facility services for 60 days, skilled nursing facility services for 30 days, or inpatient mental hospital services for 90 days (whether or not such days are consecutive), during any fiscal year, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual shall be decreased by a per centum thereof (determined under paragraph (5)) unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services, skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), such State has an effective program of medical review of the care of patients in mental hospitals, skilled nursing facilities, and intermediate care facilities pursuant to paragraphs (26) and (31) of section 1902(a) whereby the professional manage-

ment of each case is reviewed and evaluated at least annually by independent professional review teams. In determining the number of days on which an individual has received services described in this subsection, there shall not be counted any days with respect to which such individual is entitled to have payments made (in whole or in part) on his behalf under section 1812 *or section 1812A*.

* * * * * * *

PROVISIONS RESPECTING INAPPLICABILITY AND WAIVER OF CERTAIN REQUIREMENTS OF THIS TITLE

SEC. 1915. (a) * * *

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(c)(1) * * *

* * * * * * *

(3) A waiver granted under this subsection may include a waiver of the requirements of section 1902(a)(1) (relating to statewideness) [and section 1902(a)(10)(B) (relating to comparability)], *section 1902(a)(10(B) (relating to comparability), and section 1902(a)(10)(C)(i)(III) (relating to single standard for income and resource eligibility).* A waiver under this subsection shall be for an initial term of three years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met. A waiver may provide, with respect to post-eligibility treatment of income of all individuals receiving services under that waiver, that the maximum amount of the individual's income which may be disregarded for any month for the maintenance needs of the individual may be an amount greater than the maximum allowed for that purpose under regulations in effect on July 1, 1985.

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INTERNAL REVENUE CODE OF 1986

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SEC. 6050F. RETURNS RELATING TO SOCIAL SECURITY BENEFITS.

(a) REQUIREMENT OF REPORTING.—The appropriate Federal official shall make a return, according to the forms and regulations prescribed by the Secretary, setting forth—

(1) the—

(A) aggregate amount of social security benefits paid with respect to any individual during any calendar year,

(B) aggregate amount of social security benefits repaid by such individual during such calendar year, [and]

(C) aggregate reductions under section 224 of the Social Security Act (or under section 3(a)(1) of the Railroad Retirement Act of 1974) in benefits which would otherwise have been paid to such individual during the calendar year on account of amounts received under a workmen's compensation act, and

(D) the number of months any individual is covered by the insurance program established under part B of title XVIII of the Social Security Act for such calendar year, and

* * * * * * *

(b) STATEMENTS TO BE FURNISHED TO PERSONS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

(1) the name of the agency making the payments *or determining the months of coverage*, and

(2) the aggregate amount of payments, of repayments, and of reductions, *and the number of months of coverage,* with respect to the individual required to be shown on such return.

The written statement required under the preceding sentence shall be furnished to the individual on or before January 31 of the year following the calendar year for which the return under subsection (a) was required to be made.

(c) DEFINITIONS.—For purposes of this section—

(1) Appropriate federal official.—The term "appropriate Federal official" means—

(A) the Secretary of Health and Human Services in the case of social security benefits described in section 86(d)(1)(A) *and months of coverage described in subsection (a)(1)(D)*, and

(B) the Railroad Retirement Board in the case of social security benefits described in section 86(d)(1)(B).

(2) Social security benefit.—The term "social security benefit" has the meaning given to such term by section 86(d)(1).

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OMNIBUS BUDGET RECONCILIATION ACT OF 1986

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Subtitle E—Medicaid and Maternal and Child Health

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PART 2—PROVISION OF SERVICES UNDER WAIVER AUTHORITY

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SEC. 9414. NEW JERSEY RESPITE CARE PILOT PROJECT.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall enter into an agreement with the State of New Jersey (in this section referred to as the "State") for the purpose of conducting a pilot project (in this section referred to as the "project") under title XIX of the Social Security Act for providing respite care services for [elderly

and disabled individuals] *eligible individuals* in order to determine the extent to which—

* * * * * * *

(b) CONDITIONS.—The agreement with the Secretary under this section shall—

(1) provide that the project shall be administered by a State health services agency designated for such purpose by the Governor (which may be the State agency administering or responsible for the administration of the State plan for medical assistance under title XIX of the Social Security Act),

(2) provide that the State may submit a detailed proposal describing the project (in lieu of a formal request for the waiver of applicable provisions of title XIX of the Social Security Act) and that submission of such a description by the State will be treated as such a request for purposes of subsection (g),

[(2)]*(3)* provide that [if the project imposes any cost sharing requirements on participants who are eligible for benefits under title XIX of the Social Security Act, such requirements shall be imposed only in accordance with the provisions of section 1916 of such Act] *the State shall utilize a post-eligibility cost-sharing formula based on the available income of participants with income in excess of the nonfarm income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981),*

[(3)]*(4)* provide for a system of review to assure that respite care services are provided only to individuals reasonably determined to be in need of such services, and

[(4)]*(5)* meet such other requirements as the Secretary may establish for the proper and efficient implementation of the project.

[(c) DEFINITION.—For purposes of this section, the term "respite care service" shall include—

[(1) short-term and intermittent—

[(A) companion or sitter services (paid as well as volunteer),

[(B) homemaker and personal-care services,

[(C) adult day care, and

[(D) inpatient care in a hospital, a skilled nursing facility, or an intermediate care facility (not to exceed a total of 14 days for any indivdual); and

[(2) peer support and training for family caregivers (using informal support groups and organized counseling).]

(c) DEFINITIONS.—For purposes of this section—

(1) the term "eligible individual" means an individual—

(A) who is elderly or disabled,

(B)(i) whose income (not including the income of the spouse or family of the individual) does not exceed 300 percent of the amount in effect under section 1611(a)(1)(A) of the Social Security Act (as increased pursuant to section 1617 of such Act), or

(ii) in the case of an individual and spouse who are both dependent on a caregiver, whose combined incomes do not exceed such amount,

(C) at the option of the State, who meets a resource standard established by the State,

(D) who is at risk of institutionalization unless the individual's caregiver is provided with respite care, and

(E) who has been determined to meet the requirements of subparagraphs (A) through (D) in accordance with an application process designed by the State; and

(2) the term "respite care services" shall include—

(A) short-term and intermittent—

(i) companion or sitter services (paid as well as volunteer),

(ii) homemaker and personal careservices,

(iii) adult day care, and

(iv) inpatient care in a hospital, a skilled nursing facility, or an intermediate care facility (not to exceed a total of 14 days for any individual), and

(B) peer support and training for family caregivers (using informal support groups and organized counseling).

* * * * * * *

(g) PROVISIONS SUBJECT TO WAIVER.—At the request of the State, the Secretary shall waive the following provisions of title XIX of the Social Security Act as they relate to the pilot project: section 1902(a)(1), section 1902(a)(10)(B), *section 1902(a)(10)(C)(i)(III),* section 1902(a)(13), and section 1902(a)(30). The Secretary may not waive any other provision of such title with respect to the pilot project.

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100TH CONGRESS
2d Session
HOUSE OF REPRESENTATIVES
REPORT
100-661

MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

MAY 31, 1988.—Ordered to be printed

Mr. ROSTENKOWSKI, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany H.R. 2470]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2470) to amend title XVIII of the Social Security Act to provide protection against catastrophic medical expenses under the medicare program, and for other purposes, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

SECTION 1. SHORT TITLE; REFERENCES IN ACT; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Medicare Catastrophic Coverage Act of 1988".

(b) AMENDMENTS TO THE SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; references in Act; table of contents.

TITLE I—PROVISIONS RELATING TO PART A OF MEDICARE PROGRAM AND SUPPLEMENTAL MEDICARE PREMIUM

Subtitle A—Expansion of Medicare Part A Benefits

Sec. 101. Expanding scope of benefits under part A.
Sec. 102. Deductibles and coinsurance under part A.
Sec. 103. Part A premium for medicare buy-ins.

Sec. 104. Effective dates, transition, and conforming amendments.

Subtitle B—Supplemental Medicare Premium

Sec. 111. Imposition of supplemental medicare premium.
Sec. 112. Establishment of Federal Hospital Insurance Catastrophic Coverage Reserve Fund.
Sec. 113. Study of tax incentives for purchase of coverage for long-term care.

TITLE II—PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM AND TO MEDICARE SUPPLEMENTAL HEALTH INSURANCE

Subtitle A—Expansion of Medicare Part B Benefits

Sec. 201. Limitation on medicare part B cost-sharing.
Sec. 202. Coverage of catastrophic expenses for prescription drugs and insulin.
Sec. 203. Coverage of home intravenous drug therapy services.
Sec. 204. Coverage of screening mammography.
Sec. 205. In-home care for certain chronically dependent individuals.
Sec. 206. Extending home health services.
Sec. 207. Research on long-term care for medicare beneficiaries.
Sec. 208. Study of adult day care services.

Subtitle B—Medicare Part B Premium and Financing

Sec. 211. Adjustments in medicare part B premium.
Sec. 212. Establishment of Federal Catastrophic Drug Insurance Trust Fund; fund transfers.
Sec. 213. Creation of Medicare Catastrophic Coverage Account.

Subtitle C—Miscellaneous Provisions

Sec. 221. Changes in certification of medicare supplemental health insurance policies.
Sec. 222. Adjustment of contracts with prepaid health plans.
Sec. 223. Mailing of notice of medicare benefits and information describing participating physician program.
Sec. 224. Changes in civil money penalties for certain practices of health maintenance organizations and competitive medical plans.

TITLE III—PROVISIONS RELATING TO THE MEDICAID PROGRAM

Sec. 301. Requiring medicaid buy-in of premiums and cost-sharing for indigent medicare beneficiaries.
Sec. 302. Coverage and payment for pregnant women and infants with incomes below poverty line.
Sec. 303. Protection of income and resources of couple for maintenance of community spouse.

TITLE IV—UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE, OBRA TECHNICAL CORRECTIONS, AND MISCELLANEOUS PROVISIONS

Subtitle A—United States Bipartisan Commission on Comprehensive Health Care

Sec. 401. Establishment.
Sec. 402. Duties.
Sec. 403. Membership.
Sec. 404. Staff and consultants.
Sec. 405. Powers.
Sec. 406. Report.
Sec. 407. Termination.
Sec. 408. Authorization of appropriations.

Subtitle B—OBRA Technical Corrections

Sec. 411. Technical corrections to certain health care provisions in the Omnibus Budget Reconciliation Act of 1987.

Subtitle C—Miscellaneous Provisions

Sec. 421. Maintenance of efforts.
Sec. 422. Rate reduction for medicare eligible Federal employees.

Sec. 423. Study and reports by the Office of Personnel Management on offering medicare supplemental plans to Federal medicare eligible individuals, and other changes.
Sec. 424. Benefits counseling and assistance demonstration project for certain medicare and medicaid beneficiaries.
Sec. 425. Case management demonstration projects.
Sec. 426. Extensions of expiring provisions.
Sec. 427. Medicare home health care denial of benefits advisory committee.
Sec. 428. Prohibition of misuse of symbols, emblems, or names in reference to Social Security or Medicare.
Sec. 429. Demonstration projects with respect to chronic ventilator-dependent units in hospitals.

TITLE I—PROVISIONS RELATING TO PART A OF MEDICARE PROGRAM AND SUPPLEMENTAL MEDICARE PREMIUM

Subtitle A—Expansion of Medicare Part A Benefits

SEC. 101. EXPANDING SCOPE OF BENEFITS UNDER PART A.

Section 1812 (42 U.S.C. 1395d) is amended—

(1) in subsection (a), by striking paragraphs (1) through (4) and inserting the following:

"(1) inpatient hospital services;

"(2) extended care services for up to 150 days during any calendar year;

"(3) home health services; and

"(4) in lieu of certain other benefits, hospice care with respect to the individual during up to two periods of 90 days each, a subsequent period of 30 days, and a subsequent extension period with respect to which the individual makes an election under subsection (d)(1).";

(2) by amending subsection (b) to read as follows:

"(b) Payment under this part for services furnished to an individual may not be made for—

"(1) extended care services furnished to the individual during a calendar year after such services have been furnished to the individual for 150 days during that year, or

"(2) inpatient psychiatric hospital services furnished to the individual after such services have been furnished to the individual for a total of 190 days during his lifetime.";

(3) by amending subsection (c) to read as follows:

"(c)(1) If an individual is an inpatient of a psychiatric hospital on the first day of medicare entitlement (as defined in paragraph (4)(A)) payment may not be made under this part during the period described in paragraph (2) for inpatient mental health services (as defined in paragraph (4)(B)) in excess of the number of days specified in paragraph (3).

"(2) The period described in this paragraph—

"(A) begins on the first day of medicare entitlement, and

"(B) ends at the end of the first period of 60 consecutive days thereafter on each of which the individual is not receiving inpatient mental health services.

"(3) The number of days specified in this paragraph for an individual is 150 days less the number of days (during the 150-day period immediately before the first day of medicare entitlement) during which the individual was an inpatient of a psychiatric hospital.

"(4) In this subsection:

"(A) The term 'first day of medicare entitlement' means, for an individual, the first day of the first month for which the individual is entitled to benefits under this part.

"(B) The term 'inpatient mental health services' means—

"(i) inpatient psychiatric hospital services, and

"(ii) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness.";

(4) in subsection (d)—

(A) in paragraph (1), by striking "and one subsequent period of 30 days" and inserting ", a subsequent period of 30 days, and a subsequent extension period", and

(B) in paragraph (2)(B), by inserting "or a subsequent extension period" after "30-day period";

(5) in subsection (e), by striking "post-hospital", and

(6) by striking subsections (f) and (g).

SEC. 102. DEDUCTIBLES AND COINSURANCE UNDER PART A.

Section 1813 (42 U.S.C. 1395e) is amended—

(1) by amending paragraphs (1) through (3) of subsection (a) to read as follows:

"(1)(A) Subject to subparagraph (C), the amount payable for inpatient hospital services furnished to an individual during the individual's first period of hospitalization to begin during a calendar year shall be reduced by a deduction equal to the inpatient hospital deductible for that year or, if less, the charges imposed with respect to such individual for such services, except that, if the customary charges for such services are greater than the charges so imposed, such customary charges shall be considered to be the charges so imposed.

"(B) For purposes of subparagraph (A), the term 'period of hospitalization' means, with respect to an individual, the period beginning on the first day the individual is furnished inpatient hospital services and ending on the individual's date of discharge (as established by the Secretary for purposes of section 1886) from the hospital (or, in the case of a transfer, hospitals) involved.

"(C) In the case of an individual with respect to whom—

"(i) a period of hospitalization begins during December of any calendar year,

"(ii) an inpatient hospital deductible is imposed with respect to such period of hospitalization, and

"(iii) a period of hospitalization begins during January of the following calendar year,

no inpatient hospital deductible shall be imposed with respect to a period of hospitalization beginning in January of such following year (but such period of hospitalization shall not be taken into account in determining the application of an inpatient hospital de-

ductible for any period of hospitalization beginning for such individual after January 31 of such following year).

"(D) If the Secretary terminates a contract under section 1876 during a year, no inpatient hospital deductible shall be imposed during the remainder of the year in the case of an individual who can demonstrate to the satisfaction of the Secretary that, during a period of enrollment with the organization in the year, the individual was admitted to a hospital for inpatient hospital services for which the organization was obligated to make payment under such section.

"(2)(A) The amount payable to any provider of services under this part for services furnished an individual shall be further reduced by a deduction equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during each calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

"(B) The deductible under subparagraph (A) for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1833(b) to blood or blood cells furnished the individual in the year.

"(3)(A) The amount payable for extended care services furnished an individual in any calendar year shall be reduced by the coinsurance amount (promulgated under subparagraph (C) for that year) for each day (before the 9th day) on which he is furnished such services during the year.

"(B) Before September 1 of each year (beginning with 1988), the Secretary shall estimate the national average per diem reasonable cost recognized under this title for extended care services which will be furnished in the succeeding calendar year.

"(C) The Secretary shall, in September of each year (beginning with 1988) promulgate the coinsurance amount which shall apply to extended care services furnished in the succeeding year. Such amount shall be equal to 20 percent of the national average per diem cost estimated under subparagraph (B) in that year. If the coinsurance amount determined under the preceding sentence is not a multiple of 50 cents, it shall be rounded to the nearest multiple of 50 cents (or, if it is a multiple of 25 cents but not a multiple of 50 cents, to the next higher multiple of 50 cents).''; and

(2) by striking paragraph (3) of subsection (b).

SEC. 103. PART A PREMIUM FOR MEDICARE BUY-INS.

Subsection (d) of section 1818 (42 U.S.C. 1395i(2)) is amended to read as follows:

"(d)(1) The Secretary shall, during September of each year (beginning with 1988), estimate the monthly actuarial rate for months in the succeeding year. Such actuarial rate shall be one-twelfth of the amount which the Secretary estimates (on an average, per capita basis) is equal to 100 percent of the benefits and administrative costs which will be payable from the Federal Hospital Insurance Trust Fund for services performed and related administrative costs incurred in the succeeding year with respect to individuals age 65 and over who will be entitled to benefits under this part during that entire year.

"(2) The Secretary shall, during September of each year determine and promulgate the dollar amount which shall be applicable for premiums for months occurring in the following year. Such amount shall be equal to the monthly actuarial rate determined under paragraph (1) for that following year. Any amount determined under the preceding sentence which is not a multiple of $1 shall be rounded to the nearest multiple of $1 (or, if it is a multiple of 50 cents but not a multiple of $1, to the next higher multiple of $1).

"(3) Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium under this section, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for individuals 65 and older as provided in paragraph (1).".

SEC. 104. EFFECTIVE DATES, TRANSITION, AND CONFORMING AMENDMENTS.

(a) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by this subtitle shall take effect on January 1, 1989, and shall apply—

(A) to the inpatient hospital deductible for 1989 and succeeding years,

(B) to care and services furnished on or after January 1, 1989,

(C) to premiums for January 1989 and succeeding months, and

(D) to blood or blood cells furnished on or after January 1, 1989.

(2) ELIMINATION OF POST-HOSPITAL REQUIREMENT FOR EXTENDED CARE SERVICES.—The amendments made by this subtitle, insofar as they eliminate the requirement (under section 1812(a)(2) of the Social Security Act) that extended care services are only covered under title XVIII of such Act if they are post-hospital extended care services, shall only apply to extended care services furnished pursuant to an admission to a skilled nursing facility occurring on or after January 1, 1989.

(b) HOLD HARMLESS PROVISIONS.—In the case of an individual for whom a spell of illness (as defined in section 1861(a) of the Social Security Act, as in effect on December 31, 1988) began before January 1, 1989, and had not yet ended as of such date—

(1) the amendment made to section 1813(a)(1) of such Act shall not apply to services furnished during that spell of illness during 1989 or 1990, and

(2) the amount of any deductible under section 1813(a)(2) of such Act (as amended by this subtitle) shall be reduced during that spell of illness during 1989 or 1990 to the extent the deductible under such section was applied during the spell of illness.

(c) ADJUSTMENTS IN PAYMENTS FOR INPATIENT HOSPITAL SERVICES.—

(1) PPS HOSPITALS.—In adjusting DRG prospective payment rates under section 1886(d) of the Social Security Act, outlier cutoff points under section 1886(d)(5)(A) of such Act, and weighting factors under section 1886(d)(4) of such Act for discharges occurring on or after October 1, 1988, the Secretary of Health and Human Services shall, to the extent appropriate, take into consideration the reductions in payments to hospitals by medicare beneficiaries resulting from the elimination of a day limitation on medicare inpatient hospital services (under the amendment made by section 101).

(2) PPS-EXEMPT HOSPITALS.—In adjusting target amounts under section 1886(b)(3) of the Social Security Act for cost reporting periods beginning on or after October 1, 1988, the Secretary shall, on a hospital-specific basis, take into consideration the reductions in payments to hospitals by medicare beneficiaries resulting from the elimination of a day limitation on medicare inpatient hospital services (under the amendment made by section 101).

(d) MISCELLANEOUS CONFORMING AMENDMENTS.—

(1) Section 1811 (42 U.S.C. 1395c) is amended by striking "hospital, related post-hospital" and inserting "inpatient hospital services, extended care services".

(2) Section 1814 (42 U.S.C. 1395f) is amended—

(A) in paragraphs (2)(B) and (6) of subsection (a), by striking "post-hospital" each place it appears;

(B) in subsection (a)(2)(B), by striking ", for any of the conditions" and all that follows up to the semicolon;

(C) in subsection (a)(7)(A)—

(i) by striking "and" at the end of clause (i),

(ii) by striking the semicolon at the end of clause (ii) and inserting ", and", and

(iii) by adding at the end the following new clause:

"(iii) in a subsequent extension period, the medical director or physician described in clause (i)(II) recertifies at the beginning of the period that the individual is terminally ill;"; and

(D) in subsection (d)(3)—

(i) by striking "60 percent" and "80 percent" and inserting "100 percent" both places, and

(ii) by striking "two-thirds of".

(3) Section 1832(b) (42 U.S.C. 1395k(b)) is amended by striking " 'spell of illness'," and the comma before "and".

(4) Section 1861 (42 U.S.C. 1395x) is amended—

(A) by striking subsection (a);

(B) in subsection (e)—

(i) in the matter before paragraph (1), by striking "paragraph (7) of this subsection, and subsection (i) of

this section" and inserting "and paragraph (7) of this subsection",

(ii) in the third sentence, by striking "section 1814(f)(2), and subsection (i) of this section" and inserting "and section 1814(f)(2)",

(iii) in the fifth sentence, by striking ", except for purposes of subsection (a)(2),", and

(iv) by striking the second sentence;

(C) by striking subsection (i);

(D) in subsections (v)(1)(G)(i), (v)(2)(A), and (v)(3), by striking "post-hospital" each place it appears; and

(E) in subsection (y)—

(i) by striking "Post-Hospital" in the heading and by striking "post-hospital" each place it appears;

(ii) in paragraph (1), by striking "(except for purposes of subsection (a)(2))", and

(iii) in paragraphs (2) and (3), by striking "spell of illness" and "spell" each place either appears and inserting "year",

(iv) in paragraph (2)(A)(i), by striking "30 days" and inserting "45 days",

(v) in paragraph (3), by striking "one-eighth" and all that follows through "31st day" and inserting "the coinsurance amount established under section 1813(a)(3)(C) for each day before the 46th day", and

(vi) by striking paragraph (4).

(5) Section 1866(d) (42 U.S.C. 1395cc(d)) is amended by striking "post-hospital" each place it appears.

(6) Subsections (d)(1) and (f) of section 1883 (42 U.S.C. 1395tt) are amended by striking "post-hospital" each place it appears.

Subtitle B—Supplemental Medicare Premium

SEC. 111. IMPOSITION OF SUPPLEMENTAL MEDICARE PREMIUM.

(a) GENERAL RULE.—Subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to determination of tax liability) is amended by adding at the end thereof the following new part:

"PART VIII—SUPPLEMENTAL MEDICARE PREMIUM.

"Sec. 59B. Supplemental medicare premium.

"SEC. 59B. SUPPLEMENTAL MEDICARE PREMIUM.

"(a) IMPOSITION OF PREMIUM.—In the case of an individual to whom this section applies, there is hereby imposed (in addition to any other amount imposed by this subtitle) for each taxable year a supplemental premium equal to the annual premium for such year determined under subsection (c).

"(b) INDIVIDUALS SUBJECT TO PREMIUM.—This section shall apply to an individual for any taxable year if—

"(1) such individual is a medicare-eligible individual for more than 6 full months beginning in the taxable year, and

"(2) such individual's adjusted income tax liability for the taxable year equals or exceeds $150.

"(c) DETERMINATION OF AMOUNT OF SUPPLEMENTAL PREMIUM.—For purposes of this section—

"(1) IN GENERAL.—Except as otherwise provided in this subsection, the annual premium determined under this subsection with respect to any individual for any taxable year shall be equal to the product of—

"(A) the supplemental premium rate determined under subsection (d) or (e) (whichever applies) for the taxable year, multiplied by

"(B) the amount determined by dividing—

"(i) the individual's adjusted income tax liability for the taxable year, by

"(ii) $150.

"(2) LIMITATION ON ANNUAL PREMIUM.—

"(A) YEARS BEFORE 1994.—In the case of any taxable year beginning before 1994, the annual premium determined under this subsection with respect to any individual shall not exceed the limitation determined under the following table:

"In the case of taxable years beginning in:	*The limitation is:*
1989	*$800*
1990	*850*
1991	*900*
1992	*950*
1993	*1,050.*

"(B) YEARS AFTER 1993.—In the case of any taxable year beginning in a calendar year after 1993, the annual premium determined under this subsection with respect to any individual shall not exceed—

"(i) the limitation which would be in effect under this paragraph for taxable years beginning in the preceding calendar year without regard to the last sentence of this subparagraph, increased by

"(ii) the percentage (if any) by which—

"(I) the medicare-part B value for the 2nd preceding calendar year, exceeds

"(II) such value for the 3rd preceding calendar year.

If the limitation determined under the preceding sentence is not a multiple of $50, such limitation shall be rounded to the nearest multiple of $50.

"(C) MEDICARE-PART B VALUE.—

"(i) IN GENERAL.—For purposes of subparagraph (B), the term 'medicare-part B value' means, with respect to any calendar year, an amount equal to the excess of—

"(I) the average per capita part B outlays for the year, over

"(II) 12 times the monthly premium for months in such calendar year established under section 1839 of such Act (without regard to subsections (b), (f), (g)(4), and (g)(5) thereof).

"(ii) AVERAGE PER CAPITA PART B OUTLAYS.—For purposes of clause (i), the term 'average per capita part B outlays' means, with respect to a calendar year—

"(I) the outlays under part B of title XVIII of the Social Security Act for the year, divided by

"(II) the average number of individuals covered under such part during the year.

"(iii) SPECIAL RULE FOR COVERED OUTPATIENT DRUGS.—In applying the limitation under subparagraph (B) with respect to taxable years beginning in any calendar year before 1998, for purposes of this subparagraph—

"(I) the term 'outlays' does not include outlays for covered outpatient drugs (as defined in section 1861(t)(2) of the Social Security Act), and

"(II) the monthly premium shall be computed under clause (i)(II) excluding premiums under section 1839(g) of such Act attributable to the prescription drug monthly premium.

"(3) TABLES.—The annual premium shall be determined under tables which shall be prescribed by the Secretary. Such tables shall be based on the foregoing provisions of this subsection; except that such tables may have adjusted income tax liability brackets of less than $150.

"(d) DETERMINATION OF SUPPLEMENTAL PREMIUM RATE FOR YEARS BEFORE 1994.—In the case of any taxable year beginning before 1994, the supplemental premium rate determined under this subsection shall be the sum of the catastrophic coverage premium rate and the prescription drug premium rate determined under the following table:

"In the case of any taxable year beginning in:	*The catastrophic coverage premium rate is:*	*The prescription drug premium rate is:*
1989	*$22.50*	*0*
1990	*27.14*	*$10.36*
1991	*30.17*	*8.83*
1992	*30.55*	*9.95*
1993	*29.55*	*12.45.*

"(e) SUPPLEMENTAL PREMIUM RATE FOR YEARS AFTER 1993.—

"(1) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1993, except as provided in paragraph (2), the supplemental premium rate determined under this subsection shall be the sum of—

"(A) the catastrophic coverage premium rate (which would be in effect under this section for taxable years beginning in the preceding calendar year if paragraph (2) did not apply to any preceding calendar year) adjusted by the percentage determined under paragraph (3) for the calendar year in which the taxable year begins, and

"(B) the prescription drug premium rate (which would be in effect under this section for taxable years beginning in the preceding calendar year if paragraph (2) did not apply to any preceding calendar year) adjusted by the percentage

determined under paragraph (4) for the calendar year in which the taxable year begins.

"(2) SUPPLEMENTAL PREMIUM RATE CANNOT GO DOWN, AND CANNOT GO UP BY MORE THAN $1.50.—

"(A) IN GENERAL.—In no event shall the supplemental premium rate determined under this subsection for any taxable year beginning in a calendar year after 1993—

"(i) be less than, or

"(ii) exceed by more than $1.50,

the supplemental premium rate in effect under this section for taxable years beginning in the preceding calendar year.

"(B) DETERMINATION OF COMPONENT RATES WHERE SUBPARAGRAPH (A) APPLIES.—If subparagraph (A) affects the supplemental premium rate determined under this subsection for taxable years beginning in any calendar year, the supplemental premium rate determined after the application of subparagraph (A) shall be allocated between the catastrophic coverage premium rate and the prescription drug premium rate on the basis of the respective amounts of such rates without regard to the application of subparagraph (A).

"(3) PERCENTAGE ADJUSTMENT FOR CATASTROPHIC COVERAGE PREMIUM RATE.—

"(A) IN GENERAL.—The percentage determined under this paragraph for any calendar year shall be the sum of—

"(i) the outlay-premium percentage, and

"(ii) the reserve account percentage.

For purposes of the preceding sentence, negative percentages shall be taken into account as negatives.

"(B) OUTLAY-PREMIUM PERCENTAGE.—

"(i) IN GENERAL.—Except as otherwise provided in this subparagraph, the outlay-premium percentage for any calendar year is—

"(I) the percentage by which the per capita catastrophic outlays in the 2nd preceding calendar year exceed such outlays in the 3rd preceding calendar year, reduced (including below zero) by

"(II) the percentage by which the per capita catastrophic coverage premium liability for the 2nd preceding calendar year exceeds such liability for the 3rd preceding calendar year (determined as if the catastrophic coverage premium rate for the 2nd preceding calendar year were the same as the rate in effect for the 3rd preceding calendar year).

If there is no excess described in subclause (I) or (II), such subclause shall be applied by substituting 'is less than' for 'exceeds' and the percentage determined with such substitution shall be taken into account as a negative percentage.

"(ii) ADJUSTMENT FOR MORE RECENT INCREASES IN COST-OF-LIVING.—If—

"(I) the percentage increase in the CPI for the 12-month period ending with May of the preceding calendar year, exceeds (or is less than)

"(II) such increase for the 12-month period ending with May of the 2nd preceding calendar year,

by at least 1 percentage point, the percentage determined under clause (i) for the calendar year shall be adjusted up (or down, respectively) by ½ of the amount by which such excess (or shortage, respectively) exceeds 1 percent.

"(C) RESERVE ACCOUNT PERCENTAGE.—

"(i) IN GENERAL.—The reserve account percentage for any calendar year is the percentage which the rate change determined under clause (ii) is of the catastrophic coverage premium rate which would be in effect under this section for taxable years beginning in the preceding calendar year if paragraph (2) did not apply to any preceding calendar year. If there is an excess determined under clause (iii), the percentage determined under the preceding sentence shall be taken into account as a negative percentage.

"(ii) DETERMINATION OF RATE CHANGE.—The rate change determined under this clause for any calendar year is the adjustment in the catastrophic coverage premium rate (otherwise in effect for taxable years beginning in the 2nd preceding calendar year) which the Secretary determines would have resulted in an aggregate increase (or decrease) in the premiums imposed by this section for such taxable years equal to 63 percent of the shortfall or excess determined under clause (iii) for the calendar year.

"(iii) DETERMINATION OF SHORTFALL OR EXCESS.—The shortfall (or excess) determined under this clause for any calendar year is the amount by which—

"(I) 20 percent of the outlays during the 2nd preceding calendar year from the Medicare Catastrophic Coverage Account created under section 1841B of the Social Security Act, exceeds (or is less than)

"(II) the balance in such Account as of the close of such 2nd preceding calendar year (determined by taking into account previous premium increases by reason of the reserve account percentage under this subsection or by reason of section 1839(g)(2) of the Social Security Act but not credited to the Account).

"(D) DEFINITIONS.—For purposes of this paragraph—

"(i) PER CAPITA CATASTROPHIC OUTLAYS.—The term 'per capita catastrophic outlays' means, with respect to any calendar year, the amount (as determined by the Secretary of Health and Human Services) equal to—

"(I) the outlays during such year from the Medicare Catastrophic Coverage Account created under section 1841B of the Social Security Act, divided by

"(II) the average number of individuals entitled to receive benefits under part A of title XVIII of the Social Security Act during such calendar year.

"(ii) PER CAPITA CATASTROPHIC COVERAGE PREMIUM LIABILITY.—The term 'per capita catastrophic coverage premium liability' means, with respect to any calendar year, the amount (as determined by the Secretary) equal to—

"(I) the aggregate premiums imposed by this section for taxable years beginning in such calendar year to the extent attributable to the catastrophic coverage premium rate, divided by

"(II) the number of individuals who had premium liability under this section for such taxable years.

"(iii) PERCENTAGE INCREASE IN CPI.—The percentage increase in the CPI for any 12-month period shall be the percentage by which the Consumer Price Index (as defined in section 1(f)(5)) for the last month of such period exceeds such Index for the last month of the preceding 12-month period.

"(4) PERCENTAGE ADJUSTMENT FOR PRESCRIPTION DRUG PREMIUM RATE.—The percentage determined under this paragraph for any calendar year shall be determined under rules similar to the rules of paragraph (3); except that—

"(A) in determining the prescription drug premium rate for any calendar year before 1998, the following percentages shall be substituted for 20 percent in paragraph (3)(C)(iii)(I):

"In the case of calendar year:	*The percentage is:*
1994	*75*
1995	*50*
1996	*25*
1997	*25;*

"(B) no adjustment by reason of the outlay-premium percentage shall be made for any calendar year before 1998,

"(C) any reference to the Medicare Catastrophic Coverage Account shall be treated as a reference to the Federal Catastrophic Drug Insurance Trust Fund, and

"(D) any reference to the catastrophic coverage premium rate shall be treated as a reference to the prescription drug premium rate.

"(f) DEFINITIONS AND SPECIAL RULES.—

"(1) MEDICARE-ELIGIBLE INDIVIDUAL.—For purposes of this section—

"(A) IN GENERAL.—Except as otherwise provided in this paragraph, the term 'medicare-eligible individual' means, with respect to any month, any individual who is entitled to (or, on application without the payment of an additional premium, would be entitled to) benefits under part A of title XVIII of the Social Security Act for such month.

"(B) EXCEPTIONS.—The term 'medicare-eligible individual' shall not include for any month—

"(i) any individual who is entitled to benefits under part A of title XVIII of the Social Security Act for

such month solely by reason of the payment of a premium under section 1818 of such Act, or

"(ii) any qualified nonresident.

"(2) SPECIAL RULES FOR JOINT RETURNS.—In the case of a joint return—

"(A) WHERE PREMIUM APPLIES TO BOTH SPOUSES.—If both spouses meet the requirements of subsection (b)(1) for the taxable year—

"(i) such spouses shall be treated as 1 individual for purposes of applying this section, except that

"(ii) the limitation of subsection (c)(2) shall be twice the amount which would otherwise apply.

"(B) WHERE PREMIUM APPLIES TO ONLY 1 SPOUSE.—If only 1 spouse meets the requirements of subsection (b)(1) for the taxable year—

"(i) this section shall be applied separately with respect to such spouse, and

"(ii) the adjusted income tax liability of such spouse shall be determined under paragraph (4)—

"(I) by taking into account one-half of the income tax liability determined with respect to the joint return, and

"(II) by taking into account under clause (ii) of paragraph (4)(C) only amounts attributable to such spouse.

"(3) SEPARATE RETURNS BY MARRIED INDIVIDUALS.—If an individual is married as of the close of the taxable year (within the meaning of section 7703) but does not file a joint return for the taxable year and such individual does not live apart from his spouse at all times during the taxable year—

"(A) the limitation of subsection (c)(2) shall be twice the amount which would otherwise apply if both the individual and the spouse of the individual meet the requirements of subsection (b)(1) with respect to the calendar year in which the taxable year begins (determined without regard to subparagraph (B) of this paragraph),

"(B) if such individual does not otherwise meet the requirements of subsection (b)(1), such individual shall be treated as meeting the requirements of subsection (b)(1) for the taxable year if the spouse of such individual meets such requirements with respect to the calendar year in which the taxable year begins, and

"(C) in applying subparagraph (C) of paragraph (4)—

"(i) the dollar limitation of clause (i) thereof shall be 1/2 of the amount which applies to a joint return where both spouses meet the requirements of subsection (b)(1), and

"(ii) the individual shall be deemed to receive social security benefits during the taxable year in an amount not less than 1/2 of the aggregate social security benefits received by such individual and his spouse during the taxable year.

"(4) ADJUSTED INCOME TAX LIABILITY.—For purposes of this section—

"(A) IN GENERAL.—The term 'adjusted income tax liability' means an amount equal to the income tax liability, reduced by the excess (if any) of—

"(i) 15 percent of the governmental retiree exclusion amount (if any) determined under subparagraph (C) for the taxable year, over

"(ii) the amount of the credit allowable under section 22 for the taxable year.

"(B) INCOME TAX LIABILITY.—The term 'income tax liability' means—

"(i) the tax imposed by this chapter (determined without regard to this section), reduced by

"(ii) the credits allowed under part IV of this subchapter (other than under sections 31, 33, and 34).

"(C) GOVERNMENTAL RETIREE EXCLUSION AMOUNT.—The governmental retiree exclusion amount for any taxable year is the lesser of—

"(i) $6,000 ($9,000 in the case of a joint return where both spouses meet the requirements of subsection (b)(1) for the taxable year), or

"(ii) the amount which is received as an annuity (whether for a period certain or during 1 or more lives) under a governmental plan (as defined in the 1st sentence of section 414(d)) and which is includible in gross income under section 72 for the taxable year.

The amount determined under the preceding sentence shall be reduced by the social security benefits (as defined in section 86(d)) received during the taxable year.

"(D) INDEXING.—In the case of any taxable year beginning in a calendar year after 1989, subparagraph (C)(i) shall be applied by substituting for each dollar amount contained in such subparagraph an amount equal to—

"(i) the dollar amount which would be in effect under subparagraph (C)(i) for taxable years beginning in the preceding calendar year without regard to the last sentence of this subparagraph, increased by

"(ii) the cost-of-living adjustment determined under section 215(i) of the Social Security Act for the calendar year in which the taxable year begins.

Any amount determined under the preceding sentence shall be rounded to the nearest multiple of $50.

"(5) QUALIFIED NONRESIDENT.—

"(A) IN GENERAL.—For purposes of paragraph (1), the term 'qualified nonresident' means, with respect to any month during the taxable year, any individual if—

"(i) such individual is not furnished during such taxable year or any of the 4 preceding taxable years any service for which a claim for payment is made under part A of title XVIII of the Social Security Act,

"(ii) such individual is not entitled to benefits under part B of title XVIII of the Social Security Act at any time during such taxable year or any of the 4 preceding taxable years, and

"(iii) such individual is present in a foreign country or countries for at least 330 full days during—

"(I) the 12-month period ending at the close of the taxable year, and

"(II) each of the 4 consecutive preceding 12-month periods.

"(B) SPECIAL RULE FOR INDIVIDUALS WHO DIE DURING THE TAXABLE YEAR.—An individual who dies during the taxable year shall be treated as meeting the requirement of subparagraph (A)(iii)(I) if such individual is present in a foreign country or countries for at least a number of full days equal to 90 percent of the days during such taxable year before the date of death.

"(6) COORDINATION WITH OTHER PROVISIONS.—

"(A) NOT TREATED AS MEDICAL EXPENSE.—For purposes of section 213, the supplemental premium imposed by this section for any taxable year shall not be treated as an expense paid for medical care.

"(B) NOT TREATED AS TAX FOR CERTAIN PURPOSES.—The supplemental premium imposed by this section shall not be treated as a tax imposed by this chapter for purposes of determining—

"(i) the amount of any credit allowable under this chapter, or

"(ii) the amount of the minimum tax imposed by section 55.

"(C) TREATED AS TAX FOR SUBTITLE F.—For purposes of subtitle F, the supplemental premium imposed by this section shall be treated as if it were a tax imposed by section 1.

"(D) SECTION 15 NOT TO APPLY.—Section 15 shall not apply to the supplemental premium imposed by this section.

"(7) SECTION NOT TO AFFECT LIABILITY TO POSSESSIONS, ETC.—This section shall not apply for purposes of determining liability to any possession of the United States. For purposes of sections 932 and 7654, the supplemental premium imposed by this section shall not be treated as a tax imposed by this chapter.

"(8) SHORT TAXABLE YEARS.—In the case of a taxable year of less than 12 months, this section shall be applied under regulations prescribed by the Secretary."

(b) INFORMATION REPORTING.—

(1) Subsection (a) of section 6050F of such Code is amended by striking "and" at the end of paragraph (1), by redesignating paragraph (2) as paragraph (3), and by inserting after paragraph (1) the following new paragraph:

"(2) whether any individual meets the requirements of section 59B(b)(1) with respect to the calendar year (determined without regard to section 59B(f)(1)(B)(ii)), and".

(2) Section 6050F(b) of such Code is amended—

(A) by inserting "or making the determination under subsection (a)(2)" after "payments" in paragraph (1), and

(B) by inserting "and the information required under subsection (a)(2)," after "reductions," in paragraph (2).

(3) Section 6050F(c)(1)(A) of such Code is amended by inserting "and the information required under subsection (a)(2)" after "section 86(d)(1)(A)".

(c) CLERICAL AMENDMENT.—The table of parts for subchapter A of chapter 1 of such Code is amended by adding at the end thereof the following new item:

"Part VIII. Supplemental medicare premium."

(d) ANNOUNCEMENT OF SUPPLEMENTAL PREMIUM RATE.—In the case of calendar year 1993 or any calendar year thereafter—

(1) not later than July 1 of such calendar year, the Secretary of the Treasury or his delegate shall make an announcement of the estimated supplemental premium rate under section 59B of the Internal Revenue Code of 1986 for taxable years beginning in the following calendar year, and

(2) not later than October 1 of such calendar year, the Secretary of the Treasury or his delegate shall make an announcement of the actual supplemental premium rate under such section for such taxable years.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to taxable years beginning after December 31, 1988.

(2) WAIVER OF ESTIMATED TAX REQUIREMENT FOR YEARS BEGINNING IN 1989.—In the case of a taxable year beginning in 1989, the premium imposed by section 59B of the Internal Revenue Code of 1986 (as added by this section) shall not be treated as a tax for purposes of applying section 6654 of such Code.

SEC. 112. ESTABLISHMENT OF FEDERAL HOSPITAL INSURANCE CATASTROPHIC COVERAGE RESERVE FUND.

(a) IN GENERAL.—Part A of title XVIII is amended by inserting after section 1817 the following new section:

"FEDERAL HOSPITAL INSURANCE CATASTROPHIC COVERAGE RESERVE FUND

"SEC. 1817A. (a)(1) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Hospital Insurance Catastrophic Coverage Reserve Fund' (in this section referred to as the 'Reserve Fund'). The Reserve Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1) and amounts appropriated under paragraph (2).

"(2) There are hereby appropriated to the Reserve Fund, from the supplemental premiums imposed by section 59B of the Internal Revenue Code of 1986 attributable to the supplemental catastrophic premium rate, amounts equivalent to 100 percent of the amount of outlays made under this part attributable to the amendments made by the Medicare Catstrophic Coverage Act of 1988. The amounts appropriated by the preceding sentence shall be transferred from time to time (not less frequently than monthly) from the general fund in the Treasury to the Reserve Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the premiums, specified in the preceding sentence, paid to or deposited into the Treasury and on the basis of outlays, specified in the previous sentence, made; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess

of or were less than the appropriate amounts specified in such sentence. At the close of each year, the transfers under this subsection shall reflect all premiums (described in this paragraph) paid or deposited into the Treasury in the year.

"(3) With respect to monies transferred to this Fund, no transfers, authorizations of appropriations, or appropriations are permitted.

"(b) The provisions of subsections (b) through (e) of section 1817 shall apply to the Reserve Fund in the same manner as they apply to the Federal Hospital Insurance Trust Fund, except that the Board of Trustees and Managing Trustee of the Reserve Fund shall be composed of the members of the Board of Trustees and the Managing Trustee, respectively, of the Federal Hospital Insurance Trust Fund.

"(c) In this part, with respect to the Reserve Fund, the terms 'outlays' and 'receipts' mean, with respect to a quarter or other period, gross outlays and receipts, as such terms are employed in the 'Monthly Treasury Statement of Receipts and Outlays of the United States Government (MTS)', as published by the Department of the Treasury, for months in such quarter or other period.".

(b) INTEREST ADJUSTMENT.—In July 1990, the Secretary of the Treasury shall calculate the interest lost to the Federal Hospital Insurance Catastrophic Coverage Reserve Fund due to the lag between the outlays (attributable to the amendments made by this Act) from the Federal Hospital Insurance Trust Fund during 1989 and the transfers made to such Reserve Fund to cover such outlays. Appropriations under section 1817A(a)(2) of the Social Security Act (as inserted by subsection (a)) shall include the amount calculated under the previous sentence.

SEC. 113. STUDY OF TAX INCENTIVES FOR PURCHASE OF COVERAGE FOR LONG-TERM CARE.

(a) IN GENERAL.—The Secretary of the Treasury (in this section referred to as the "Secretary") shall conduct a study of Federal tax policies to promote the private financing of long-term care (as defined in subsection (d)). The study shall identify alternative methods of creating incentives, through the tax system, to encourage individuals to purchase insurance coverage for long-term care. The study shall also consider the cost to the United States Treasury and the potential benefits to consumers, including whether the incentives would benefit all or most of the population requiring protection.

(b) CONSULTATION.—The Secretary shall conduct the study required by subsection (a) in consultation with representatives of the insurance industry, providers of long-term care, and consumers.

(c) REPORT.—The Secretary shall report the results of the study required by subsection (a) to the Congress not later than November 30, 1988, together with the Secretary's recommendations for any changes in Federal law that the Secretary determines to be appropriate to promote the private financing of long-term care.

(d) LONG-TERM CARE DEFINED.—For purposes of this section, the term "long-term care" includes care and services provided by nursing homes, home health agencies, and other mechanisms for the delivery of long-term care services.

TITLE II—PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM AND MEDICARE SUPPLEMENTAL HEALTH INSURANCE

Subtitle A—Expansion of Medicare Part B Benefits

SEC. 201. LIMITATION ON MEDICARE PART B COST-SHARING.

(a) IN GENERAL.—Section 1833 (42 U.S.C. 1395l) is amended—

(1) in subsection (c)—

(A) by striking "subsections (a) and (b)" and inserting "subsection (a) through (c)",

(B) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B),

(C) by striking "this subsection" and inserting "this paragraph", and

(D) by striking "(c)" and inserting "(d)(1)";

(2) by redesignating subsection (d) as paragraph (2);

(3) in subsection (g), by striking "(a) and (b)" inserting "(a) through (c)"; and

(4) by inserting after subsection (b) the following new subsection:

"(c)(1) Notwithstanding subsections (a) and (b), if an individual has incurred out-of-pocket part B cost sharing (as defined in paragraph (2)) in a calendar year (beginning with 1990) in an amount equal to the part B catastrophic limit (established under paragraph (3)) for the year, payment under this part with respect to any additional incurred expenses in the calendar year shall be made as if—

"(A) the deduction described in the second sentence of subsection (b) (relating to blood) no longer applied, and

"(B) '100 percent' and '0 percent' were substituted for '80 percent' and '20 percent', respectively, each place either appears in subsections (a) and (i)(2), in sections 1834(a)(1)(A), 1834(e)(1)(C), 1835(b)(2), and 1866(a)(2)(A) and in subsections (b)(2) and (b)(3) of section 1881, except as such provisions may apply to in-home care.

"(2) In this subsection, the term 'out-of-pocket part B cost sharing' means, with respect to an individual covered under this part, the amounts of expenses that the individual incurs that are attributable to—

"(A) the deductions established under subsection (b), and

"(B) the difference between the payment amount provided under this part and the payment amount that would be provided if '100 percent' and '0 percent' were substituted for '80 percent' and '20 percent', respectively, each place either appears in subsections (a) and (i)(2), in sections 1834(a)(1)(A), 1834(e)(1)(C), 1835(b)(2), and 1866(a)(2)(A) and in subsections (b)(2) and (b)(3) of section 1881.

"(3)(A) The part B catastrophic limit for 1990 is $1370. The part B catastrophic limit for any succeeding year shall be such an amount

(rounded to the nearest multiple of $1) as the Secretary estimates will result, in that succeeding year, in 7 percent of the average number of individuals enrolled under this part (other than individuals enrolled with an eligible organization under section 1876 or an organization described in subsection (a)(1)(A)) during the year becoming entitled to benefits under this subsection.

"(B) Not later than September 1 of each year (beginning with 1990), the Secretary shall promulgate the part B catastrophic limit under this paragraph for the succeeding year.

"(4) In the case of an organization receiving payment under clause (A) of subsection (a)(1) or under a reasonable cost reimbursement contract under section 1876, in applying paragraph (1), the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect the aggregate increase in payments that would otherwise be made with respect to enrollees in such an organization if payments were made other than under such clause or such a contract on an individual-by-individual basis.

"(5)(A) Except as provided in subparagraph (B), expenses incurred by a medicare beneficiary for out-of-pocket part B cost-sharing shall be counted (consistent with subparagraph (C)) whether or not, at the time the expenses were incurred, the beneficiary was enrolled in a plan under section 1833(a)(1)(A) or under section 1876. In this paragraph, with respect to a medicare beneficiary enrolled in such a plan, the term 'out-of-pocket part B cost-sharing' includes deductibles and coinsurance under the plan for items and services covered under this part.

"(B) In the case of a medicare beneficiary enrolled in a month in a buy-out plan (as defined in subparagraph (D))—

"(i) expenses incurred by the beneficiary for items and services reimbursed under the plan shall not be treated as out-of-pocket part B cost-sharing for purposes of paragraph (1), but

"(ii) the beneficiary is deemed to have incurred, for each month of such enrollment, expenses for out-of-pocket part B cost-sharing in an amount equal to the actuarial value (with respect to a month in the year involved) of the deductible and coinsurance amounts under part B (as computed by the Secretary for purposes of section 1876(e)(1), other than with respect to covered outpatient drugs) applicable on the average to individuals in the United States.

"(C) The Secretary may not enter into a contract with an organization under section 1876, or provide for payment under section 1833(a)(1)(A) with respect to an organization, with respect to a plan that is not a buy-out plan, unless the organization provides assurances, satisfactory to the Secretary, that—

"(i) the organization will maintain and make available, for its enrollees and in coordination with the appropriate carriers under this part, an accounting of expenses incurred in each year under the plan for out-of-pocket part B cost-sharing (as defined in subparagraph (A)); and

"(ii) the organization will not undertake to charge a beneficiary during a year for services for which payment may be made under this part (other than for covered outpatient drugs) after the individual has incurred (whether through the organization or otherwise) out-of-pocket part B cost sharing in the year in an

amount equal to the part B catastrophic limit established under paragraph (1) for the year.

"(D) In this paragraph, the term 'buy-out plan' means a plan under section 1833(a)(1)(A) or offered by an organization under section 1876 and with respect to which—

"(i) the actuarial value of the coinsurance and deductibles under the plan with respect to benefits (other than covered outpatient drugs) under this title (as determined by the Secretary), is less than 50 percent of—

"(ii) the actuarial value of the coinsurance and deductibles for such benefits for all medicare beneficiaries (as determined by the Secretary) applicable on the average to individuals in the United States.

"(E) In this subsection, the term 'medicare beneficiary' means, with respect to a month, an individual covered for benefits under this part for the month.".

(b) LIMITATION ON CHARGES WHEN CATASTROPHIC LIMIT REACHED.—Section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended by adding at the end the following new sentence: "A provider of services may not impose a charge under the first sentence of this subparagraph for services for which payment is made to the provider pursuant to section 1833(c) (relating to catastrophic benefits).".

(c) NOTICE FOR BENEFICIARIES REACHING CATASTROPHIC LIMIT.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

(1) by striking "and" at the end of subparagraph (G),

(2) by inserting "and" at the end of subparagraph (H), and

(3) by inserting after subparagraph (H) the following new subparagraph:

"(I) will provide each individual, who is determined to have incurred (or has had paid on the individual's behalf) sufficient out-of-pocket part B cost sharing in a calendar year to qualify for payment for additional incurred expenses to be made pursuant to section 1833(c), with a notice that states that the individual has reached the part B catastrophic limit on out-of-pocket cost sharing for the year;".

(d) CONFORMING AMENDMENT.—The second sentence of section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended by striking "1833(c)" and inserting "1833(d)(1)".

SEC. 202. COVERAGE OF CATASTROPHIC EXPENSES FOR PRESCRIPTION DRUGS AND INSULIN.

(a) DESCRIPTION OF COVERED OUTPATIENT DRUGS.—Section 1861 (42 U.S.C. 1395x) is amended—

(1) by amending subparagraph (J) of subsection (s)(2) to read as follows:

"(J) covered outpatient drugs (as defined in subsection (t)); and", and

(2) in subsection (t)—

(A) by inserting "and paragraph (2)" after "subsection (m)(5)",

(B) by inserting "(1)" after "(t)", and

(C) by adding at the end the following new paragraph:

"(2) Subject to paragraph (3), the term 'covered outpatient drug' means—

"(A) a drug which may be dispensed only upon prescription and—

"(i) which is approved for safety and effectiveness as a prescription drug under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act or which is approved under section 505(j) of such Act;

"(ii)(I) which was commercially used or sold in the United States before the date of the enactment of the Drug Amendments of 1962 or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) which has not been the subject of a final determination by the Secretary that it is a 'new drug' (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act to enforce section 502(f) or 505(a) of such Act; or

"(iii)(I) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling;

"(B) a biological product which—

"(i) may only be dispensed upon prescription,

"(ii) is licensed under section 351 of the Public Health Service Act, and

"(ii) is produced at an establishment licensed under such section to produce such product; and

"(C) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act.

"(3)(A) The term 'covered outpatient drug' does not include any drug, biological product, or insulin provided as, as part of, or as incident to, any of the following (and for which payment may be included under this title):

"(i) Inpatient hospital services (described in subsection (b)(2)).

"(ii) Extended care services (described in subsection (h)(5)).

"(iii) Physicians' services under subparagraph (A) or (B) of subsection (s)(2).

"(iv) Dialysis supplies under subsection (s)(2)(F).

"(v) Antigens under subsection (s)(2)(G).

"(vi) Blood clotting factors for hemophiliacs under subsection (s)(2)(I).

"(vii) Services of a physician assistant under subsection (s)(2)(K)(ii).

"(viii) Pneumococcal, hepatitis B, or influenza vaccines under subsection (s)(10).

"(ix) Rural health clinic services (under subsection 1861(aa)(1)).

"(x) Comprehensive outpatient rehabilitation facility services (under subsection 1861(cc)(1)).

"(xi) Hospice care (as defined in subsection (dd)(1)).

"(xii) Certified nurse-midwife service (as defined in subsection (gg)(1)).

"(xiii) A covered surgical procedure in an ambulatory surgical center (under section 1832(a)(2)(F)(i)).

"(B) With respect to covered outpatient drugs dispensed in 1990, the term 'covered outpatient drug' is limited—

"(i) to drugs described in paragraph (2)(A) used in immunosuppressive therapy, and

"(ii) to covered home IV drugs (as defined in paragraph (4)).

"(C) The term 'covered outpatient drug' does not include a drug that is intravenously administered in a home setting unless it is a covered home IV drug.

"(4)(A) The term 'covered home IV drug' means a covered outpatient drug dispensed to an individual that—

"(i) is intravenously administered in a place of residence used as the individual's home, and

"(ii)(I) is an antibiotic drug and the Secretary has not determined, for the specific drug or for the indication to which it is applied, that the drug cannot generally be administered safely and effectively in a home setting, or

"(II) is not an antibiotic drug and the Secretary has determined, for the specific drug and the indication for which the drug is being applied, that the drug can generally be administered safely and effectively in a home setting.

"(B) Not later than January 1, 1990 (and periodically thereafter), the Secretary shall publish a list of the drugs, and indications for such drugs, that are covered home IV drugs (as defined in subparagraph (A)), with respect to which home intravenous drug therapy may be provided under this title.".

(b) DEDUCTIBLE AND PAYMENT AMOUNTS.—Part B is amended—

(1) in subsection (a)(1) of section 1833 (42 U.S.C. 1395l(b)), as amended by section 411(h)(7)(A)(v)(I) of this Act—

(A) by striking "and" before "(L)", and

(B) by adding at the end the following: "and (M) with respect to expenses incurred for covered outpatient drugs, the amounts paid shall be the amounts determined under section 1834(c)(2)";

(2) in subsection (a)(2) of such section by inserting "(other than covered outpatient drugs)" after "(2) in the case of services";

(3) in subsection (b) of such section—

(A) in clause (1), by inserting "or for covered outpatient drugs" after "1861(s)(10)(A)", and

(B) in clause (2), by inserting "or with respect to covered outpatient drugs" after "home health services"; and

(3) by adding at the end of section 1834 (42 U.S.C. 1395m) the following new subsection:

"(c) PAYMENT FOR COVERED OUTPATIENT DRUGS.—

"(1) DEDUCTIBLE.—

"(A) APPLICATION.—

"(i) IN GENERAL.—Except as provided in clauses (ii) and (iii), payment shall be made under paragraph (2) only with respect to expenses incurred by an individual for covered outpatient drugs during a calendar year on or after such date in the year as the Secretary determines that the individual has incurred expenses in the year for covered outpatient drugs (during a period in which the individual is entitled to benefits under this part) equal to the amount of the catastrophic drug deductible specified in subparagraph (C) for that year.

"(ii) DEDUCTIBLE NOT APPLIED FOR POST-HOSPITAL HOME INTRAVENOUS DRUG THERAPY.—The catastrophic drug deductible established under this paragraph shall not apply to covered home IV drugs dispensed in conjunction with home intravenous drug therapy services which are part of a continuous course of such therapy initiated while the individual was an inpatient in a hospital.

"(iii) DEDUCTIBLE NOT APPLIED TO 1ST YEAR IMMUNOSUPPRESSIVES.—The catastrophic drug deductible established under this paragraph shall not apply to drugs described in subsection (t)(2)(A) used in immunosuppressive therapy and furnished, to an individual who receives an organ transplant for which payment is made under this title, within 1 year after the date of the transplant.

"(B) RESPONSE TO APPLICATION.—If the system described in section 1842(o)(4) has not been established and an individual applies to the Secretary to establish that the individual has met the requirement of subparagraph (A), the Secretary shall promptly notify the individual (and, if the application was submitted by or through a participating pharmacy, the pharmacy) as to the date (if any) as of which the individual has met such requirement.

"(C) CATASTROPHIC DRUG DEDUCTIBLE AMOUNT.—

"(i) IN GENERAL.—Subject to subparagraph (D), the catastrophic drug deductible specified in this subparagraph for—

"(I) 1990 is $550,

"(II) 1991 is $600,

"(III) 1992 is $652, and

"(IV) any succeeding year, is such an amount as the Secretary determines will result in 16.8 percent of the average number of individuals covered under this part (other than individuals enrolled with an eligible organization under section 1876 or an organization described in section 1833(a)(1)(A)) during that succeeding year having incurred expenses for covered outpatient drugs sufficient to meet the catastrophic drug deductible so determined.

"(ii) ROUNDING.—Any amount determined under this subparagraph which is not a multiple of $1 shall be rounded to the nearest multiple of $1.

"(iii) PUBLICATION.—Before May 1 of each year (beginning with 1992) the Secretary shall publish in the Federal Register a proposed regulation establishing the amount of the catastrophic drug deductible under this subparagraph for the following year. During the last 3 days of September of such year, the Secretary shall publish in the Federal Register the final regulation establishing the amount of such deductible for the following year, which amount may not be greater than the amount specified in the proposed regulation.

"(2) PAYMENT AMOUNT.—

"(A) IN GENERAL.—Subject to the catastrophic drug deductible established under paragraph (1)(A) and except as provided in subparagraph (C), the amounts payable under this part with respect to a covered outpatient drug is equal to the payment percent (specified in subparagraph (B)) of the lesser of—

"(i) the actual charge for the drug, or

"(ii) the applicable payment limit established under paragraph (3).

(B) PAYMENT PERCENT.—For purposes of subparagraph (A), the payment percent is 100 percent minus the applicable coinsurance percent (specified in subparagraph (C)).

"(C) COINSURANCE PERCENT.—For purposes of subparagraph (B), the coinsurance percent—

"(i) for covered home IV drugs and for drugs described in paragraph (1)(A)(iii) (relating to immunosuppressive therapy during 1st year after transplant), is 20 percent; and

"(ii) for other covered outpatient drugs dispensed—

"(I) in 1990 or 1991, is 50 percent,

"(II) in 1992 is 40 percent, and

"(III) in 1993 or a succeeding year is 20 percent.

"(D) TREATMENT OF CERTAIN COST-BASED PREPAID ORGANIZATIONS.—In applying subparagraph (A) in the case of an organization under a reasonable cost reimbursement contract under section 1876 and in the case of an organization receiving payment under section 1833(a)(1)(A) and providing coverage of covered outpatient drugs, the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect the aggregate increase in payments that would otherwise be made with respect to enrollees in such an organization if payments were made other than under such clause or such a contract on an individual-by-individual basis.

"(3) PAYMENT LIMITS.—

"(A) PAYMENT LIMIT FOR NON-MULTIPLE SOURCE DRUGS AND MULTIPLE-SOURCE DRUGS WITH RESTRICTIVE PRESCRIPTIONS.—In the case of a drug that either is not a multiple source drug (as defined in paragraph (9)(A)) or is a multiple source drug and has a restrictive prescription (as defined in

paragraph (9)(B)), the payment limit for the drug under this paragraph for a payment calculation period is equal to the lesser of—

"(i) the 90th percentile of the actual charges (computed on a statewide basis, carrier-wide basis, or other appropriate geographic area basis, as specified by the Secretary) for the drug for the second previous payment calculation period, adjusted (as the Secretary determines to be appropriate) to reflect the number of tablets (or other dosage units) dispensed; or

"(ii) the amount of the administrative allowance (established under paragraph (4)) plus the product of—

"(I) the number of tablets (or other dosage units) dispensed, and

"(II) the per tablet or unit average wholesale price for such drug (as determined under subparagraph (C) for the period for purposes of this subparagraph);

except that clause (i) shall not apply to covered outpatient drugs dispensed before January 1, 1992.

"(B) PAYMENT LIMIT FOR MULTIPLE SOURCE DRUGS WITHOUT RESTRICTIVE PRESCRIPTIONS.—In the case of a drug that is a multiple source drug but does not have a restrictive prescription, the payment limit for the drug under this paragraph for a payment calculation period is equal to the amount of the administrative allowance (established under paragraph (4)) plus the product of—

"(i) the number of tablets (or other dosage units) dispensed, and

"(ii) the unweighted median of the per tablet or unit average wholesale prices (determined under subparagraph (C) for purposes of this subparagraph) for such drug for the period.

"(C) DETERMINATION OF UNIT PRICE.—

"(i) IN GENERAL.—For purposes of this paragraph, the Secretary shall determine, with respect to the dispensing of a covered outpatient drug in a payment calculation period (beginning on or after January 1, 1990), the per tablet or unit average wholesale price for the drug.

"(ii) BASIS FOR DETERMINATIONS.—

"(I) DETERMINATION FOR NON-MULTIPLE-SOURCE DRUGS.—For purposes of subparagraph (A), such determination shall be based on a biannual survey conducted by the Secretary of a representative sample of direct sellers, wholesalers, or pharmacies (as appropriate) of wholesale (or comparable direct) prices (excluding discounts to pharmacies); except that if, because of low volume of sales for the drug or other appropriate reasons or in the case of covered outpatient drugs during 1990, the Secretary determines that such a survey is not appropriate with respect to a specific drug, such determination

shall be based on published average wholesale (or comparable direct) prices for the drug.

"(II) DETERMINATION FOR MULTIPLE-SOURCE DRUGS.—For purposes of subparagraph (B), the Secretary may base the determination under this subparagraph on the published average wholesale (or comparable direct) prices for the drug or on a biannual survey conducted by the Secretary of a representative sample of direct sellers, wholesalers, or pharmacists (as appropriate) of wholesale (or comparable direct) prices (excluding discounts to pharmacies).

"(III) COMPLIANCE WITH SURVEY REQUIRED.—If a wholesaler or direct seller of a covered outpatient drug refuses, after being requested by the Secretary, to provide the information required in a survey under this clause, or deliberately provides information that is false, the Secretary may impose a civil money penalty of not to exceed $10,000 for each such refusal or provision of false information. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). Information gathered pursuant to the survey shall not be disclosed except as the Secretary determines to be necessary to carry out the purposes of this part.

"(iii) QUANTITY AND TIMING.—Such determination shall be based on the price or prices for purchases in reasonable quantities and shall be made for a payment calculation period based on prices for the first day of the first month of the previous payment calculation period.

"(iv) GEOGRAPHIC BASIS.—The Secretary shall make such determination, and calculate the payment limits under this paragraph, on a national basis; except that the Secretary may make such determination, and calculate such payment limits, on a regional basis to take account of limitations on the availability of drug products and variations among regions in the average wholesale prices for a drug product.

"(4) ADMINISTRATIVE ALLOWANCE FOR PURPOSES OF PAYMENT LIMITS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), for drugs dispensed in—

"(i) 1990 or 1991, the administrative allowance under this paragraph is—

"(I) $4.50 for drugs dispensed by a participating pharmacy, or

"(II) $2.50 for drugs dispensed by another pharmacy; or

"(ii) a subsequent year, the administrative allowance under this paragraph is the administrative allowance

under this paragraph for the preceding year increased by the percentage increase (if any) in the implicit price deflator for gross national product (as published by the Department of Commerce in its 'Survey of Current Business') over the 12-month period ending with August of such preceding year.

Any allowance determined under the clause (ii) which is not a multiple of 1 cent shall be rounded to the nearest multiple of 1 cent.

"(B) ADJUSTMENT IN ALLOWANCE FOR MAIL SERVICE PHARMACIES.—The Secretary may, by regulation and after consultation with pharmacists, elderly groups, and private insurers, reduce the administrative allowances established under subparagraph (A) for any drug dispensed by a mail service pharmacy (as defined by the Secretary) based on differences between such pharmacies and other pharmacies with respect to operating costs and other economies.

"(5) ASSURING APPROPRIATE PRESCRIBING AND DISPENSING PRACTICES.—

"(A) IN GENERAL.—The Secretary shall establish a program to identify (and to educate physicians and pharmacists concerning)—

"(i) instances or patterns of unnecessary or inappropriate prescribing or dispensing practices for covered outpatient drugs,

"(ii) instances or patterns of substandard care with respect to such drugs, and

"(iii) potential adverse reactions.

"(B) STANDARDS.—In carrying out the program under subparagraph (A), the Secretary shall establish for each covered outpatient drug standards for the prescribing of the drug which are based on accepted medical practice. In establishing such standards, the Secretary shall incorporate standards from such current authoritative compendia as the Secretary may select; except that the Secretary may modify such a standard by regulation on the basis of scientific and medical information that such standard is not consistent with the safe and effective use of the drug.

"(C) PROHIBITION OF FORMULARY.—Nothing in this title (including paragraph (8)), other than sections 1861(t)(4)(A) and 1862(c), shall be construed as authorizing the Secretary to exclude from coverage or to deny payment—

"(i) for any specific covered outpatient drug, or specific class of covered outpatient drug, or

"(ii) for any specific use of such a drug for a specific indication unless such exclusion is pursuant to section 1862(a)(1) based on a finding by the Secretary that such use is not safe or is not effective.

"(6) TREATMENT OF CERTAIN PREPAID ORGANIZATIONS.—

"(A) GENERAL RULE COUNTING PREPAID PLAN EXPENSES TOWARDS THE CATASTROPHIC DRUG DEDUCTIBLE.—Except as provided in subparagraph (B), expenses incurred by (or on behalf of) a medicare beneficiary for covered outpatient drugs shall be counted (consistent with subparagraph (C))

toward the catastrophic drug deductible established under paragraph (1) whether or not, at the time the expenses were incurred, the beneficiary was enrolled in a plan under section 1833(a)(1)(A) or under section 1876.

"(B) TREATMENT OF DRUG BUY-OUT PLAN EXPENSES.—In the case of a medicare beneficiary enrolled in a month in a drug buy-out plan (as defined in subparagraph (D))—

"(i) expenses incurred by the beneficiary for covered outpatient drugs reimbursed under the plan shall not be counted towards the catastrophic drug deductible, but

"(ii) if the individual disenrolls from the plan during the year, the beneficiary is deemed to have incurred, for each month of such enrollment, expenses for covered outpatient drugs in an amount equal to the actuarial value (with respect to such month) of the deductible for covered outpatient drugs (as computed by the Secretary for purposes of section 1876(e)(1)) applicable on the average to individuals in the United States.

"(C) TREATMENT OF EXPENSES FOR COVERED OUTPATIENT DRUGS INCURRED WHILE ENROLLED IN A PREPAID PLAN OTHER THAN A DRUG BUY-OUT PLAN.—The Secretary may not enter into a contract with an organization under section 1876, or provide for payment under section 1833(a)(1)(A) with respect to an organization which provides reimbursement for covered outpatient drugs, with respect to a plan that is not a drug buy-out plan, unless the organization provides assurances, satisfactory to the Secretary, that—

"(i) the organization will maintain and make available, for its enrollees and in coordination with the appropriate carriers under this part, an accounting of expenses incurred by (or on behalf of) enrollees under the plan for covered outpatient drugs; and

"(ii) the organization will take into account, in any deductibles established under the plan in a year with respect to covered outpatient drugs under this part, the amounts of expenses for covered outpatient drugs incurred in the year by (or on behalf of) the beneficiary and otherwise counted towards the catastrophic drug deductible in the year.

"(D) DRUG BUY-OUT PLAN DEFINED.—In this paragraph, the term 'drug buy-out plan' means a plan under section 1833(a)(1)(A) or offered by an organization under section 1876 and with respect to which—

"(i) the amount of any deductible under the plan with respect to covered outpatient drugs under this title,

is less than 50 percent of—

"(ii) the catastrophic drug deductible specified in paragraph (1)(C).

"(E) MEDICARE BENEFICIARY DEFINED.—In this subsection, the term 'medicare beneficiary' means, with respect to a month, an individual covered for benefits under this part for the month.

"(F) TREATMENT OF PLAN CHARGES.—In the case of covered outpatient drugs furnished by an eligible organization under section 1876(b) or an organization described in section 1833(a)(1)(A) which does not impose charges on covered outpatient drugs dispensed to its members, for purposes of this subsection the actual charges of the organization shall be the organization's standard charges to members, and other individuals, not entitled to benefits with respect to such drugs.

"(7) PHYSICIAN GUIDE.—

"(A) IN GENERAL.—The Secretary shall develop, and update annually, an information guide for physicians concerning the comparative average wholesale prices of at least 500 of the most commonly prescribed covered outpatient drugs. Such guide shall, to the extent practicable, group covered outpatient drugs (including multiple source drugs) in a manner useful to physicians by therapeutic category or with respect to the conditions for which they are prescribed. Such guide shall specify the average wholesale prices on the basis of the amount of the drug required for a typical daily therapeutic regimen.

"(B) MAILING GUIDE.—The Secretary shall provide for mailing, in January of each year (beginning with 1991), a copy of the guide developed and updated under subparagraph (A)—

"(i) to each hospital with an agreement in effect under section 1866,

"(ii) to each physician (as defined in section 1861(r)(1)) who routinely provides services under this part, and

"(iii) to Social Security offices, senior citizen centers, and other appropriate places.

"(8) REPORTS ON OUTLAYS AND RECEIPTS; SPECIAL COST CONTROLS.—

"(A) COMPILATION OF INFORMATION.—The Secretary shall compile information on—

"(i) manufacturers' prices for covered outpatient drugs, and on charges of pharmacists for covered outpatient drugs, and

"(ii) the use of covered outpatient drugs by individuals entitled to benefits under this part.

The information compiled under clause (i) shall include a comparison of the increases in prices and charges for covered outpatient drugs during each 6 month period (beginning with January 1987) with the semiannual average increase in such prices and charges during the 6 years beginning with 1981.

"(B) REPORTS.—The Secretary shall submit to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate a report, in May and November of 1989 and 1990 and in May of each succeeding year, providing the information compiled under subparagraph (A). For each such report submitted after 1991, the report shall in-

clude an explanation of the extent to which the increases in outlays for covered outpatient drugs under this part are due to the factors described in subparagraphs (A)(i) and (A)(ii).

"(C) MONTHLY REPORTS ON OUTLAYS AND RECEIPTS.—Within 30 days after the end of each month (beginning with October 1991 and ending with April 1993), the Secretary shall report to Congress on the outlays and receipts of the Federal Catastrophic Drug Insurance Trust Fund (in this paragraph referred to as the 'Trust Fund') in the month.

"(D) BUDGETARY INFORMATION.—

"(i) IN GENERAL.—In each report submitted under subparagraph (B) after 1991, the Secretary shall include information on—

"(I) the projected budgetary status of the Trust Fund for the succeeding year,

"(II) the projected increases in manufacturers' prices for covered outpatient drugs and in charges of pharmacists for covered outpatient drugs,

"(III) the projected level of utilization of covered outpatient drugs by medicare beneficiaries, and

"(IV) the projected administrative costs relating to covered outpatient drugs.

"(ii) DETERMINATION AND PUBLICATION OF ANY OUTLAY CONTROLS FOR 1993 AND 1994.—For each such report in 1992 and 1993, the Secretary—

"(I) shall determine in the report whether the anticipated outlays and receipts of the Trust Fund for the succeeding year will provide for at least the minimum contingency margin specified in subparagraph (F) for that succeeding year, and

"(II) if not, shall include in the report (and shall publish in the Federal Register by May 1 of the year a proposed regulation to carry out) changes in the provisions of this part (consistent with subparagraph (E)) in order to reduce outlays from the Trust Fund in that succeeding year sufficiently to provide for the minimum contingency margin specified in subparagraph (F).

Any changes described in subclause (II) in such report shall reflect appropriately each of the anticipated causes of increased or unanticipated outlays for covered outpatient drugs.

"(iii) EFFECTIVENESS OF REGULATORY CHANGES.—If proposed regulations are published under clause (ii)(II) in 1992 or 1993, during the last 3 days of September of such year, the Secretary shall publish in the Federal Register a final regulation to implement the changes described in such clause. Notwithstanding any other provision of this part, but subject to subparagraph (E) and unless otherwise provided by law, such changes shall become effective on January 1 of the succeeding year and shall apply only during that succeeding year. Such final regulation may not revise the proposed regu-

lation in a manner that would result in a greater reduction in outlays than would have been the case under the proposed regulation.

"(E) LIMITATION ON CHANGES.—In making regulatory changes under subparagraph (D), the Secretary may not—

"(i) provide for a formulary (in violation of paragraph (5)(C));

"(ii) change the methodology for determining whether for a year an individual has met the catastrophic drug deductible established under paragraph (1)(A); or

"(iii) increase the coinsurance percent under paragraph (2)(C) for a year above the coinsurance percent in effect during the previous year.

Clause (ii) shall not be construed as prohibiting the Secretary from increasing the amount of the catastrophic drug deductible under paragraph (1)(A).

"(F) MINIMUM CONTINGENCY MARGIN DEFINED.—In this paragraph, the term 'minimum contingency margin' means—

"(i) for 1993, 50 percent, and

"(ii) for 1994, 25 percent.

Such margin shall be determined as of the close of each calendar year and shall be determined based on the total outlays from the Trust Fund during the year.

"(9) DEFINITIONS.—In this subsection:

"(A) MULTIPLE SOURCE DRUG.—

"(i) IN GENERAL.—The term 'multiple source drug' means, with respect to a payment calculation period, a covered outpatient drug for which there are 2 or more drug products which—

"(I) are rated as therapeutically equivalent (under the Food and Drug Administration's most recent publication of 'Approved Drug Products with Therapeutic Equivalence Evaluations',

"(II) except as provided in clause (ii), are pharmaceutically equivalent and bioequivalent, as defined in clause (iii) and as determined by the Food and Drug Administration, and

"(III) are sold or marketed during the period.

"(ii) EXCEPTION.—Subclause (II) of clause (i) shall not apply if the Food and Drug Administration changes by regulation (after an opportunity for public comment of 90 days) the requirement that, for purposes of the publication described in clause (i)(I), in order for drug products to be rated as therapeutically equivalent, they must be pharmaceutically equivalent and bioequivalent, as defined in clause (iii).

"(iii) DEFINITIONS.—For purposes of this subparagraph:

"(I) PHARMACEUTICALLY EQUIVALENT.—Drug products are pharmaceutically equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form

and meet compendial or other applicable standards of strength, quality, purity, and identity.

"(II) BIOEQUIVALENT.—Drugs are bioequivalent if they do not present a known or potential bioequivalence problem or, if they do present such a problem, are shown to meet an appropriate standard of bioequivalence.

"(III) SOLD OR MARKETED.—A drug is considered to be sold or marketed during a period if it is listed in the publications referred to in clause (i)(I), unless the Secretary determines that such sale or marketing is not actually taking place.

"(B) RESTRICTIVE PRESCRIPTION.—A drug has a 'restrictive prescription' only if—

"(i) in the case of a written prescription, the prescription for the drug indicates, in the handwriting of the physician or other person prescribing the drug and with an appropriate phrase (such as 'brand medically necessary') recognized by the Secretary, that the particular drug must be dispensed, or

"(ii) in the case of a prescription issued by telephone—

"(I) the physician or other person prescribing the drug (through use of such an appropriate phrase) states that the particular drug must be dispensed, and

"(II) the physician or other person submits to the pharmacy involved, within 30 days after the date of the telephone prescription, a written confirmation which is in the handwriting of the physician or other person prescribing the drug and which indicates with such appropriate phrase that the particular drug was required to have been dispensed.

"(C) PAYMENT CALCULATION PERIOD.—The term 'payment calculation period' means the 6-month period beginning with January of each year and the 6-month period beginning with July of each year.

"(D) OUTLAYS; RECEIPTS.—The terms 'outlays' and 'receipts' mean, with respect to a year or other period, gross outlays and receipts, as such terms are employed in the 'Monthly Treasury Statement of Receipts and Outlays of the United States Government (MTS)', as published by the Department of the Treasury, for months in such year or other period.".

(c) PARTICIPATING PHARMACIES; CIVIL MONEY PENALTIES.—

(1) PARTICIPATING PHARMACIES.—Section 1842 (42 U.S.C. 1395t) is amended—

(A) in subsection (h)(1), by inserting before the period at the end of the second sentence the following: ", except that, with respect to a supplier of covered outpatient drugs, the term 'participating supplier' means a participating pharmacy (as defined in subsection (o)(1))";

(B) in subsection (h)(4), is amended by adding at the end the following: "In publishing directories under this para-

graph, the Secretary shall provide for separate directories (wherever appropriate) for participating pharmacies."; and

(C) by adding at the end the following new subsection:

"(o)(1) For purposes of this section, the term 'participating pharmacy' means, with respect to covered outpatient drugs dispensed on or after January 1, 1991, an entity which is authorized under a State law to dispense covered outpatient drugs and which has entered into an agreement with the Secretary, providing at least the following:

"(A) The entity agrees to accept payment under this part on an assignment-related basis for all covered outpatient drugs dispensed to an individual entitled to benefits under this part (in this subsection referred to as 'medicare beneficiaries') during a year after—

"(i) the Secretary has notified the entity, through the electronic system described in subparagraph (D)(i), or

"(ii) in the absence of such a system, the entity is otherwise notified that the Secretary has determined,

that the individual has met the catastrophic drug deductible with respect to such drugs under section 1834(c)(1) for the year.

"(B) The entity agrees—

"(i) not to refuse to dispense covered outpatient drugs items stocked by the entity to any medicare beneficiary, and

"(ii) not to charge medicare beneficiaries (regardless of whether or not the beneficiares are enrolled under a prepaid health plan or with eligible organization under section 1876) more for such drugs than the amount it charges to the general public (as determined by the Secretary in regulations).

"(C) The entity agrees to keep patient records (including records on expenses) for all covered outpatient drugs dispensed to all medicare beneficiaries.

"(D) The entity agrees to submit information (in a manner specified by the Secretary to be necessary to administer this title) on all purchases of covered outpatient drugs dispensed to medicare beneficiaries.

"(E) The entity agrees—

"(i) to offer to counsel, or to offer to provide information (consistent with State law respecting the provision of such information) to, each medicare beneficiary on the appropriate use of a drug to be dispensed and whether there are potential interactions between the drug and other drugs dispensed to the beneficiary; and

"(ii) to advise the beneficiary on the availability (consistent with State laws respecting substitution of drugs) of therapeutically equivalent covered outpatient drugs.

"(F) The entity agrees to provide the information requested by the Secretary in surveys under section 1834(c)(3)(C)(ii).

Nothing in this paragraph shall be construed as requiring a pharmacy operated by an eligible organization (described in section 1876(b)) or an organization described in section 1833(a)(1)(A) for the exclusive benefit of its members to dispense covered outpatient drugs to individuals who are not members of the organization.

"(2) The Secretary shall provide to each participating pharmacy—

"(A) a distinctive emblem (suitable for display to the public) indicating that the pharmacy is a participating pharmacy, and

"(B) upon request, such electronic equipment and technical assistance (other than the costs of obtaining, maintaining, or expanding telephone service) as the Secretary determines may be necessary for the pharmacy to submit claims using the electronic system established under paragraph (4).

"(3) The Secretary shall provide for periodic audits of participating pharmacies to assure—

"(A) compliance with the requirements for participation under this title, and

"(B) the accuracy of information submitted by the pharmacies under this title.

"(4) The Secretary shall establish, by not later than January 1, 1991, a point-of-sale electronic system for use by carriers and participating pharmacies in the submission of information respecting covered outpatient drugs dispensed to medicare beneficiaries under this part.

"(5) Notwithstanding subsection (b)(3)(B), payment for covered outpatient drugs may be made on the basis of an assignment described in clause (ii) of that subsection only to a participating pharmacy.".

(2) CIVIL MONEY PENALTIES FOR VIOLATION OF PARTICIPATION AGREEMENT, FOR EXCESSIVE CHARGES FOR NONPARTICIPATING PHARMACIES AND FOR FAILURE TO PROVIDE SURVEY INFORMATION.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(A) by striking "or" at the end of paragraph (1),

(B) in paragraph (2)(C), by inserting "or to be a participating pharmacy under section 1842(o)" after "1842(h)(1)",

(C) by striking ", or" at the end of paragraph (2) and inserting a semicolon,

(D) by adding "or" at the end of paragraph (3), and

(E) by inserting after paragraph (3) the following new paragraph:

"(4) in the case of a participating or nonparticipating pharmacy (as defined for purposes of part B of title XVIII)—

"(A) presents or causes to be presented to any person a request for payment for covered outpatient drugs dispensed to an individual entitled to benefits under part B of title XVIII and for which the amount charged by the pharmacy is greater than the amount the pharmacy charges the general public (as determined by the Secretary in regulations), or

"(B) fails to provide the information requested by the Secretary in a survey under section 1834(c)(3)(C)(ii);".

(d) LIMITATION ON LENGTH OF PRESCRIPTION.—Section 1862(c) (42 U.S.C. 1395y(c)) is amended—

(1) by redesignating subparagraphs (A) through (D) of paragraph (1) as clauses (i) through (iv), respectively;

(2) in paragraph (2)(A), by striking "paragraph (1)" and inserting "subparagraph (A)";

(3) by redesignating subparagraphs (A) and (B) of paragraph (2) as clauses (i) and (ii), respectively;

(4) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively;

(5) by inserting "(1)" after "(c)"; and

(6) by adding at the end the following new paragraph:

"(2) No payment may be made under part B for any expense incurred for a covered outpatient drug if the drug is dispensed in a quantity exceeding a supply of 30 days or such longer period of time (not to exceed 90 days, except in exceptional circumstances) as the Secretary may authorize.".

(e) USE OF CARRIERS, FISCAL INTERMEDIARIES, AND OTHER ENTITIES IN ADMINISTRATION.—

(1) AUTHORIZING USE OF OTHER ENTITIES IN ELECTRONIC CLAIMS SYSTEM.—Section 1842(f) (42 U.S.C. 1395u(f)) is amended—

(A) by striking "and" at the end of paragraph (1),

(B) by striking the period at the end of paragraph (2) and inserting "; and", and

(C) by adding at the end the following new paragraph:

"(3) with respect to implementation and operation (and related functions) of the electronic system established under subsection (o)(4), a voluntary association, corporation, partnership, or other nongovernmental organization, which the Secretary determines to be qualified to conduct such activities.".

(2) ADDITIONAL FUNCTIONS OF CARRIERS.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)), as amended by section 201(c) of this Act, is amended—

(A) by striking "and" at the end of subparagraph (H), and

(B) by inserting after subparagraph (I) the following new subparagraphs:

"(J) if it makes determinations or payments with respect to covered outpatient drugs, will—

"(i) receive information transmitted under the electronic system established under subsection (o)(4), and

"(ii) respond to requests by participating pharmacies (and individuals entitled to benefits under this part) as to whether or not such an individual has met the catastrophic drug deductible established under section 1834(c)(1)(A) for a year; and

"(K) will enter into such contracts with organizations described in subsection (f)(3) as the Secretary determines may be necessary to implement and operate (and for related functions with respect to) the electronic system established under subsection (o)(4) for covered outpatient drugs under this part;".

(3) SPECIAL CONTRACT PROVISIONS FOR ELECTRONIC CLAIMS SYSTEM.—

(A) PAYMENT ON OTHER THAN A COST BASIS.—Section 1842(c)(1)(A) is amended—

(i) by inserting "(i)" after "(c)(1)(A)",

(ii) in the first sentence, by inserting ", except as provided in clause (ii)," after "under this part, and", and

(iii) by adding at the end the following new clause:

"(ii) To the extent that a contract under this section provides for implementation and operation (and related functions) of the electronic system established under subsection (o)(4) for covered outpatient drugs, the Secretary may provide for payment for such activi-

ties based on any method of payment determined by the Secretary to be appropriate.".

(B) APPLICATION OF DIFFERENT PERFORMANCE STANDARDS.—The Secretary of Health and Human Services, before entering into contracts under section 1842 of the Social Security Act with respect to the implementation and operation (and related functions) of the electronic system for covered outpatient drugs, shall establish standards with respect to performance with respect to such activities. The provisions of section 1153(e)(2), and paragraphs (1) and (2) of section 1153(h), of such Act shall apply to such activities in the same manner as they apply to contracts with peer review organizations, instead of the requirements of the last 2 sentences of section 1842(b)(2) of such Act.

(C) USE OF REGIONAL CARRIERS.—Section 1842(b)(2) is amended by adding at the end the following new sentence: "With respect to activities relating to implementation and operation (and related functions) of the electronic system established under subsection (o)(4), the Secretary may enter into contracts with carriers under this section to perform such activities on a regional basis.".

(4) ADJUSTMENT OF CARRIER OBLIGATIONS.—

(A) NO TOLL-FREE TELEPHONE NUMBER REQUIRED OF LIMITED CARRIERS.—Section 1842(h)(2) (42 U.S.C. 1395u(h)(2)) is amended by inserting "(other than a carrier described in subsection (f)(3))" after "Each carrier".

(B) DELAY IN APPLICATION OF COORDINATED BENEFITS WITH MEDIGAP.—The provisions of subparagraph (B) of section 1842(h)(3) of the Social Security Act shall not apply to covered outpatient drugs (other than drugs described in section 1861(s)(2)(J) of such Act as of the date of the enactment of this Act) dispensed before January 1, 1993.

(5) BATCH PROMPT PROCESSING OF CLAIMS.—Section 1842(c) (42 U.S.C. 1395u(c)) is amended—

(A) in paragraphs (2)(A) and (3)(A), by striking "Each" and inserting "Except as provided in paragraph (3), each";

(B) by adding at the end the following new paragraph:

"(4)(A) Each contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), with respect to claims for payment for covered outpatient drugs shall provide for a payment cycle under which each carrier will, on a monthly basis, make a payment with respect to all claims which were received and approved for payment in the period since the most recent date on which such a payment was made with respect to the participating pharmacy or individual submitting the claim.

"(B) If payment is not issued, mailed, or otherwise transmitted within 5 days of when such a payment is required to be made under subparagraph (A), interest shall be paid at the rate used for purposes of section 3902(a) of title 31, United States Code (relating to interest penalties for failure to make prompt payments) for the period beginning on the day after such 5-day period and ending on the date on which payment is made.".

(f) MODIFICATION OF HMO/CMP CONTRACTS.—

(1) SEPARATE ACTUARIAL DETERMINATION FOR COVERED OUTPATIENT DRUG BENEFIT.—Section 1876(e)(1) (42 U.S.C. 1395mm(e)(1)) is amended by adding at the end thereof the following new sentence: "The preceding sentence shall be applied separately with respect to covered outpatient drugs.".

(2) ADDITIONAL OPTIONAL BENEFITS.—Section 1876(g)(3)(A) (42 U.S.C. 1395mm(g)(3)(A)) is amended by striking "rate" and inserting "rates".

(g) REQUIRING SUBMISSION OF DIAGNOSTIC INFORMATION.—Section 1842 (42 U.S.C. 1395u), as amended by subsection (c)(1)(D), is amended by adding at the end the following new subsection:

"(p)(1) Each request for payment, or bill submitted, for an item or service furnished by a physician for which payment may be made under this part shall include the appropriate diagnosis code (or codes) as established by the Secretary for such item or service.

"(2) In the case of a request for payment for an item or service furnished by a physician on an assignment-related basis which does not include the code (or codes) required under paragraph (1), payment may be denied under this part.

"(3) In the case of a request for payment for an item or service furnished by a physician not submitted on an assignment-related basis and which does not include the code (or codes) required under paragraph (1)—

"(A) if the physician knowingly and willfully fails to provide the code (or codes) promptly upon request of the Secretary or a carrier, the physician may be subject to a civil money penalty in an amount not to exceed $2,000, and

"(B) if the physician knowingly, willfully, and in repeated cases fails, after being notified by the Secretary of the obligations and requirements of this subsection, to include the code (or codes) required under paragraph (1), the physician may be subject to the sanction described in section 1842(j)(2)(A).

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under subparagraph (A) in the same manner as they apply to a penalty or proceeding under section 1128A(a).".

(h) CONFORMING AMENDMENTS.—

(1) The first sentence of section 1866(a)(2)(A) (42 U.S.C. 1395cc(a)(2)(A)) is amended—

(A) by inserting "1834(c)," after "1833(b)," and

(B) by inserting "and in the case of covered outpatient drugs, applicable coinsurance percent (specified in section 1834(c)(2)(C)) of the lesser of the actual charges for the drugs or the payment limit (established under section 1834(c)(3))" after "established by the Secretary".

(2) Section 1903(i)(5) (42 U.S.C. 1396b(i)(5)) is amended by striking "section 1862(c)" and inserting "section 1862(c)(1)".

(i) REPORTS ON MEDICARE BENEFICIARY DRUG EXPENSES.—

(1) HHS.—The Secretary of Health and Human Services, by not later than April 1, 1989—

(A) using data from the 1987 National Medical Expenditures Survey (conducted by the National Center for Health Services Research and Health Care Technology Assessment), shall report to Congress on expenses incurred by

medicare beneficiaries for outpatient prescription drugs, and

(B) shall provide the Director of the Congressional Budget Office with such data from that Survey as the Director may request to make the estimates required under paragraph (2).

(2) REESTIMATION OF COSTS.—The Director of the Congressional Budget Office shall transmit to the Congress, not later June 1, 1989, or, if later, 60 days after the date of providing data requested under paragraph (1)(B), the Director's estimate of the outlays which will be made (in each of fiscal years 1990, 1991, 1992, and 1993) under the medicare program for covered outpatient drugs (under the amendments made by this section).

(j) PRESCRIPTION DRUG PAYMENT REVIEW COMMISSION.—Part B is amended by adding at the end the following new section:

"PRESCRIPTION DRUG PAYMENT REVIEW COMMISSION

"SEC. 1847. (a)(1) The Director of the Congressional Office of Technology Assessment (in this section referred to as the 'Director' and the 'Office', respectively) shall provide for the appointment of a Prescription Drug Payment Review Commission (in this section referred to as the 'Commission'), to be composed of individuals with expertise in the provision and financing of covered outpatient drugs appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service).

"(2) The Commission shall consist of 11 individuals. Members of the Commission shall first be appointed by no later than January 1, 1989, for a term of 3 years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than 4 members expire in any one year.

"(3) The membership of the Commission shall include recognized experts in the fields of health care economics, medicine, pharmacology, pharmacy, and prescription drug reimbursement, as well as at least one individual who is a medicare beneficiary.

"(b)(1) The Commission shall submit to Congress an annual report no later than May 1 of each year, beginning with 1990, concerning methods of determining payment for covered outpatient drugs under this part.

"(2) Such report, in 1992 and thereafter, shall include, with respect to the previous year, information on—

"(A) increases in manufacturers' prices for covered outpatient drugs and in charges of pharmacists for covered outpatient drugs,

"(B) the level of utilization of covered outpatient drugs by medicare beneficiaries, and

"(C) administrative costs relating to covered outpatient drugs.

"(3) Such report, in 1992 and thereafter, shall include comments on the budgetary status of the Federal Catastrophic Drug Insurance Trust Fund and recommendations for any reductions in outlays that may be required to achieve the contingency margin (established under section 1841A(d) for the following year, taking into account

each of the causes of increased or unanticipated outlays for covered outpatient drugs in the year.

"(c) Section 1845(c)(1) shall apply to the Commission in the same manner as it applies to the Physician Payment Review Commission.

"(d) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Such sums shall be payable from the Federal Catastrophic Drug Insurance Trust Fund.".

(k) ADDITIONAL STUDIES.—

(1) HHS.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall conduct the following studies, and report to Congress on the results of each such study by the following dates:

(A) A study of the possibility of including drugs which have not yet been approved under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act and biological products which have not been licensed under section 351 of the Public Health Service Act but which are commonly used in the treatment of cancer or in immunosuppressive therapy and other experimental drugs and biological products as covered outpatient drugs under the medicare program, for which a report shall be made by January 1, 1990. The study under this subparagraph shall be conducted in consultation with an advisory board of consumers, experts in the fields of cancer chemotherapy and immunosuppressive therapy, representatives of pharmaceutical manufacturers, and such other individuals as the Secretary may select.

(B) A study to evaluate the potential to use mail service pharmacies to reduce costs to the medicare program and to medicare beneficiaries, for which a report shall be made by January 1, 1990.

(C) A study of methods to improve utilization review of covered outpatient drugs, for which the report shall be made by January 1, 1993.

(D) A longitudinal study, to be conducted as a follow-up to the data collected under the survey referred to in subsection (j)(1)(A), on the use of outpatient prescription drugs by medicare beneficiaries with respect to medical necessity, potential for adverse drug interactions, cost (including whether lower cost drugs could have been used), and patient stockpiling or wastage, for which a report shall be made by January 1, 1993.

(2) GAO.—The Comptroller General shall conduct the following studies, and report to Congress on the results of each such study by not later than May 1, 1991:

(A) A study comparing average wholesale prices with actual pharmacy acquisition costs by type of pharmacy.

(B) A study to determine the overhead costs of retail pharmacies.

(C) A study of the discounts given by pharmacies to other third-party insurers.

Pharmacies which fail to provide the Comptroller General with reasonable access to necessary records to carry out the studies under this paragraph are subject to exclusion from the medi-

care and medicaid programs under section 1128(a) of the Social Security Act.

(l) DEVELOPMENT OF STANDARD MEDICARE CLAIMS FORM.—

(1) The Secretary shall develop, in consultation with representatives of pharmacies and other interested individuals, a standard claims form (and a standard electronic claims format) to be used in requests for payment for covered outpatient drugs under the medicare program and other third-party payors.

(2) Not later than October 1, 1989, the Secretary shall distribute official sample copies of the format developed under paragraph (1) to pharmacies and other interested parties and by not later than October 1, 1990, shall distribute official sample copies of the form developed under paragraph (1) to pharmacies and other interested parties.

(m) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall apply to items dispensed on or after January 1, 1990.

(2) CARRIERS.—The amendments made by subsection (e) shall take effect on the date of the enactment of this Act; except that the amendments made by subsection (e)(5) shall take effect on January 1, 1991, but shall not be construed as requiring payment before February 1, 1991.

(3) HMO/CMP ENROLLMENTS.—The amendment made by subsection (f) shall apply to enrollments effected on or after January 1, 1990.

(4) DIAGNOSTIC CODING.—The amendment made by subsection (g) shall apply to services furnished after March 31, 1989.

(5) TRANSITION.—With respect to administrative expenses (and costs of the Prescription Drug Payment Review Commission) for periods before January 1, 1990, amounts otherwise payable from the Federal Catastrophic Drug Insurance Trust Fund shall be payable from the Federal Supplementary Medical Insurance Trust Fund and shall also be treated as a debit to the Medicare Catastrophic Coverage Account.

SEC. 203. COVERAGE OF HOME INTRAVENOUS DRUG THERAPY SERVICES.

(a) IN GENERAL.—Section 1832(a)(2)(A) (42 U.S.C. 1395k(a)(2)(A)) is amended by inserting "and home intravenous drug therapy services" before the semicolon.

(b) HOME INTRAVENOUS DRUG THERAPY SERVICES DEFINED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"(jj)(1) The term 'home intravenous drug therapy services' means the items and services described in paragraph (2) furnished to an individual who is under the care of a physician—

"(A) in a place of residence used as such individual's home;

"(B) by a qualified home intravenous drug therapy provider (as defined in paragraph (3)) or by others under arrangements with them made by such provider; and

"(C) under a plan established and periodically reviewed by a physician.

"(2) The items and services described in this paragraph are such nursing, pharmacy, and related services (including medical supplies,

intravenous fluids, delivery, and equipment) as are necessary to conduct safely and effectively an intravenously administered drug regimen through use of a covered home IV drug (as defined in subsection (t)(4)), but do not include such covered outpatient drugs.

"(3) The term 'qualified home intravenous drug therapy provider' means any entity that the Secretary determines meets the following requirements:

"(i) The entity is capable of providing or arranging for the items and services described in paragraph (2) and covered home IV drugs.

"(ii) The entity maintains clinical records on all patients.

"(iii) The entity adheres to written protocols and policies with respect to the provision of items and services.

"(iv) The entity makes services available (as needed) seven days a week on a 24-hour basis.

"(v) The entity coordinates all services with the patient's physician.

"(vi) The entity conducts a quality assessment and assurance program, including drug regimen review and coordination of patient care.

"(vii) The entity assures that only trained personnel provide covered home IV drugs (and any other service for which training is required to safely provide the service).

"(viii) The entity assumes responsibility for the quality of services provided by others under arrangements with the agency or entity.

"(ix) In the case of an entity in any State in which State or applicable local law provides for the licensing of entities of this nature, (I) is licensed pursuant to such law, or (II) is approved, by the agency of such State or locality responsible for licensing entities of this nature, as meeting the standards established for such licensing.

"(x) The entity meets such other requirements as the Secretary may determine are necessary to assure the safe and effective provision of home intravenous drug therapy services and the efficient administration of the home intravenous drug therapy benefit.".

(c) PAYMENT.—

(1) IN GENERAL.—Part B is amended—

(A) in subsection (a)(2)(B) of section 1833 (42 U.S.C. 1395l), by striking "or (E)" and inserting "(E), or (F)";

(B) in subsection (a)(2)(D) of such section, by striking "and" at the end;

(C) in subsection (a)(2)(E) of such section, by striking the semicolon and inserting "; and";

(D) by inserting after subsection (a)(2)(E) of such section the following new subparagraph:

"(F) with respect to home intravenous drug therapy services, the amounts described in section 1834(d)(1);"

(E) in subsection (b) of such section, by striking "services, (3)" and inserting "services and home intravenous drug therapy services, (3)"; and

(F) by adding at the end of section 1834, as amended by section 202(b)(3) of this Act, the following new subsection:

"(d) HOME INTRAVENOUS DRUG THERAPY SERVICES.—

"(1) IN GENERAL.—With respect to home intravenous drug therapy services, subject to paragraph (3), payment under this part shall be made in an amount equal to the lesser of the actual charges for such services or the fee schedule established under paragraph (2).

"(2) ESTABLISHMENT OF FEE SCHEDULE.—The Secretary shall establish by regulation before the beginning of calendar year 1990 and each succeeding calendar year a fee schedule for home intravenous drug therapy services for which payment is made under this part. A fee schedule established under this subsection shall be on a per diem basis.

"(3) LIMITATION ON ACCEPTANCE OF, AND PAYMENTS FOR, CERTAIN REFERRALS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), a home intravenous drug therapy provider may not provide home intravenous drug therapy services under this part to an individual if the individual's referring physician (as defined in subparagraph (D)), or an immediate family member of the physician—

"(i) has an ownership interest in the provider, or

"(ii) receives compensation from the provider.

"(B) EXCEPTIONS.—

"(i) Subparagraph (A)(i) shall not apply—

"(I) if the ownership interest is the ownership of stock which is traded over a publicly-regulated exchange and was purchased on terms generally available to the public, or

"(II) if the provider is a sole home intravenous drug therapy provider (as defined by the Secretary) in a rural area.

"(ii) Subparagraph (A)(ii) shall not apply if the compensation is reasonably related to items or services actually provided by the physician and does not vary in proportion to the number of referrals made by the referring physician, but such exception shall not apply to compensation provided for direct patient care services.

"(iii) Subparagraph (A) shall not be construed to apply to a referring physician whose only ownership or financial relationship with the provider is as an uncompensated officer or director of the provider.

"(iv) Subparagraph (A) also shall not apply in such cases, established by the Secretary in regulations, in which the nature of the ownership or compensation does not pose a substantial risk of program abuse.

"(C) SANCTIONS.—

"(i) DENIAL OF PAYMENT.—No payment may be made under this part for home intravenous drug therapy services which are provided in violation of subparagraph (A).

"(ii) CIVIL MONEY PENALTY FOR IMPROPER CLAIMS.—Any person (including a home intravenous drug therapy provider or physician) that presents or causes to be presented a claim for an item or service that such

person knows or should know is for an item or service for which payment may not be made under subparagraph (A) shall be subject to a civil money penalty of not more than $15,000 for each such item or service. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(D) REFERRING PHYSICIAN DEFINED.—In this paragraph, the term 'referring physician' means, with respect to providing home intravenous drug therapy services to an individual, a physician who—

"(i) prescribed the covered home IV drug for which the services are to be provided, or

"(ii) established the plan of care for such services.".

(2) PROPAC STUDY.—The Prospective Payment Assessment Commission shall conduct a study, and make recommendations to Congress and the Secretary of Health and Human Services by not later than March 1, 1991, concerning appropriate adjustment to the payment amounts provided under section 1886(d) of the Social Security Act for inpatient hospital services to account for reduced costs to hospitals resulting from the amendments made by this section.

(3) INSPECTOR GENERAL REPORT ON POTENTIALLY ABUSIVE OWNERSHIP OR COMPENSATION ARRANGEMENTS.—The Inspector General of the Department of Health and Human Services shall study and report to Congress, by not later than May 1, 1989, concerning—

(A) physician ownership of, or compensation from, an entity providing items or services to which the physician makes referrals and for which payment may be made under the medicare program;

(B) the range of such arrangements and the means by which they are marketed to physicians;

(C) the potential of such ownership or compensation to influence the decision of a physician regarding referrals and to lead to inappropriate utilization of such items and services; and

(D) the practical difficulties involved in enforcement actions against such ownership and compensation arrangements that violate current anti-kickback provisions.

Such report shall include such recommendations as may be appropriate to strengthen current law provisions to prevent program abuse.

(d) CERTIFICATION.—

(1) IN GENERAL.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)) is amended—

(A) by striking "and" at the end of subparagraph (E);

(B) by striking the period at the end of subparagraph (F) and inserting "; and"; and

(C) by inserting after subparagraph (F) the following new subparagraph:

"(G) in the case of home intravenous drug therapy services, (i) such services are or were required because the individual needed such services for the administration of a covered home IV drug, (ii) a plan for furnishing such services has been established and is reviewed periodically by a physician, (iii) such services are or were furnished while the individual is or was under the care of a physician, (iv) such services are administered in a place of residence used as such individual's home, and (v) with respect to such services initiated before January 1, 1993, such services have been reviewed and approved by a utilization and peer review organization under section 1154(a)(16) before the date such services were initiated (or, in the case of services first initiated on an outpatient basis, within 1 working day (except in exceptional circumstances) of the date of initiation of the services).".

(2) PRO PRIOR APPROVAL REQUIRED.—Section 1154(a) (42 U.S.C. 1320c-3(a)) is amended by adding at the end the following new paragraph:

"(16) The organization shall perform the review described in paragraph (1) with respect to home intravenous drug therapy services (as defined in section 1861(jj)(1)) initiated before January 1, 1993, within 1 working day of the date of the organization's receipt of a request for such review. The Secretary shall establish criteria to be used by such an organization in conducting reviews with respect to the appropriateness of home intravenous drug therapy services under this paragraph.".

(e) CERTIFICATION OF HOME INTRAVENOUS DRUG THERAPY PROVIDERS; INTERMEDIATE SANCTIONS FOR NONCOMPLIANCE.—

(1) TREATMENT AS PROVIDER OF SERVICES.—Section 1861(u) (42 U.S.C. 1395x(u)) is amended by inserting "home intravenous drug therapy provider," after "hospice program,".

(2) CONSULTATION WITH STATE AGENCIES AND OTHER ORGANIZATIONS.—Section 1863 (42 U.S.C. 1395z) is amended by striking "and (dd)(2)" and inserting "(dd)(2), and (jj)(3)".

(3) USE OF STATE AGENCIES IN DETERMINING COMPLIANCE.—Section 1864(a) (42 U.S.C. 1395aa(a)) is amended—

(A) in the first sentence, by inserting "or a home intravenous drug therapy provider," after "hospice program", and

(B) in the second sentence, by striking "or hospice program" and inserting "hospice program, or home intravenous drug therapy provider".

(4) APPLICATION OF INTERMEDIATE SANCTIONS.—Section 1846 (42 U.S.C. 1395w-2) is amended—

(A) in the heading, by adding "AND FOR QUALIFIED HOME INTRAVENOUS DRUG THERAPY PROVIDERS" at the end;

(B) in subsection (a), by inserting "or that a qualified home intravenous drug therapy provider that is certified for participation under this title no longer substantially meets the requirements of section 1861(jj)(3)" after "under this part"; and

(C) in subsection (b)(2)(A)(iv) by inserting "or home intravenous drug therapy services" after "clinical diagnostic laboratory tests".

(f) USE OF REGIONAL INTERMEDIARIES IN ADMINISTRATION OF BENEFIT.—Section 1816 (42 U.S.C. 1395h) is amended by adding at the end thereof the following new subsection:

"(k) With respect to carrying out functions relating to payment for home intravenous drug therapy services and covered home IV drugs, the Secretary may enter into contracts with agencies or organizations under this section to perform such functions on a regional basis.".

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1990.

SEC. 204. COVERAGE OF SCREENING MAMMOGRAPHY.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) is amended—

(1) in subsection (s)—

(A) by redesignating paragraphs (13) and (14) as paragraphs (14) and (15), respectively,

(B) by striking "and" at the end of paragraph (11),

(C) by striking the period at the end of paragraph (12) and inserting "; and", and

(D) by inserting after paragraph (12) the following new paragraph:

"(13) screening mammography (as defined in subsection (kk)).";

and

(2) by adding at the end the following new subsection:

"Screening Mammography

"(kk) The term 'screening mammography' means a radiologic procedure provided to a woman for the purpose of early detection of breast cancer and includes a physician's interpretation of the results of the procedure.".

(b) PAYMENT AND COVERAGE.—Section 1834 (42 U.S.C. 1395m), as amended by sections 202(b)(3) and 203(c)(1)(F) of this Act, is amended—

(1) in subsection (b)(1)(B), by inserting "and subject to subsection (e)(1)(A)" after "conversion factors", and

(2) by adding at the end the following new subsection:

"(e) PAYMENTS AND STANDARDS FOR SCREENING MAMMOGRAPHY.—

"(1) IN GENERAL.—Notwithstanding any other provision of this part (except as provided in section 1833(c)), with respect to expenses incurred for screening mammography (as defined in section 1861(kk))—

"(A) payment may be made only for screening mammography conducted consistent with the frequency permitted under paragraph (2);

"(B) payment may be made only if the screening mammography meets the quality standards established under paragraph (3); and

"(C) the amount of the payment under this part shall, subject to the deductible established under section 1833(b), be equal to 80 percent of the least of—

"(i) the actual charge for the screening,

"(ii) the fee schedule established under subsection (b) with respect to both the professional and technical

components of the screening mammography, in the case of screening mammography subject to such schedule but for this paragraph, or

"(iii) the limit established under paragraph (4) for the screening mammography.

"(2) FREQUENCY COVERED.—

"(A) IN GENERAL.—Subject to revision by the Secretary under subparagraph (B)—

"(i) No payment may be made under this part for screening mammography performed on a woman under 35 years of age.

"(ii) Payment may be made under this part for only 1 screening mammography performed on a woman over 34 years of age, but under 40 years of age.

"(iii) In the case of a woman over 39 years of age, but under 50 years of age, who—

"(I) is at a high risk of developing breast cancer (as determined pursuant to factors identified by the Secretary), payment may not be made under this part for a screening mammography performed within the 11 months of a previous screening mammography, or

"(II) is not at a high risk of developing breast cancer, payment may not be made under this part for a screening mammography performed within the 23 months after a previous screening mammography.

"(iv) In the case of a woman over 49 years of age, but under 65 years of age, payment may not be made under this part for screening mammography performed within 11 months after a previous screening mammography.

"(v) In the case of a woman over 64 years of age, payment may not be made for screening mammography performed within 23 months after a previous screening mammography.

"(B) REVISION OF FREQUENCY.—

"(i) REVIEW.—The Secretary, in consultation with the Director of the National Cancer Institute, shall review periodically the appropriate frequency for performing screening mammography, based on age and such other factors as the Secretary believes to be pertinent.

"(ii) REVISION OF FREQUENCY.—The Secretary, taking into consideration the review made under clause (i), may revise from time to time the frequency with which screening mammography may be paid for under this subsection, but no such revision shall apply to screening mammography performed before January 1, 1992.

"(3) QUALITY STANDARDS.—The Secretary shall establish standards to assure the safety and accuracy of screening mammography performed under this part. Such standards shall include the requirements that—

"(A) the equipment used to perform the mammography must be specifically designed for mammography and must meet radiologic standards established by the Secretary for mammography;

"(B) the mammography must be performed by an individual who—

"(i) is licensed by a State to perform radiological procedures, or

"(ii) is certified as qualified to perform radiological procedures by such an appropriate organization as the Secretary specifies in regulations;

"(C) the results of the mammography must be interpreted by a physician—

"(i) who is certified as qualified to interpret radiological procedures by such an appropriate board as the Secretary specifies in regulations, or

"(ii) who is certified as qualified to interpret screening mammography procedures by such a program as the Secretary recognizes in regulation as assuring the qualifications of the individual with respect to such interpretation; and

"(D) with respect to the first screening mammography performed on a woman for which payment is made under this part, there are satisfactory assurances that the results of the mammography will be placed in permanent medical records maintained with respect to the woman.

"(4) LIMIT.—

"(A) $50, INDEXED.—Except as provided by the Secretary under subparagraph (B), the limit established under this paragraph—

"(i) for screening mammography performed in 1990, is $50, and

"(ii) for screening mammography performed in a subsequent year is the limit established under this paragraph for the preceding year increased by the percentage increase in the MEI for that subsequent year.

"(B) REDUCTION OF LIMIT.—The Secretary shall review from time to time the appropriateness of the amount of the limit established under this paragraph. The Secretary may, with respect to screening mammography performed in a year after 1991, reduce the amount of such limit as it applies nationally or in any area to the amount that the Secretary estimates is required to assure that screening mammography of an appropriate quality is readily and conveniently available during the year.

"(C) APPLICATION OF LIMIT IN HOSPITAL OUTPATIENT SETTING.—The Secretary shall provide for an appropriate allocation of the limit established under this paragraph between professional and technical components in the case of hospital outpatient screening mammography (and comparable situations) where there is a claim for professional services separate from the claim for the radiologic procedure.

"(5) LIMITING CHARGES OF NONPARTICIPATING PHYSICIANS.—

"(A) IN GENERAL.—In the case of mammography screening performed on or after January 1, 1990, for which payment is made under this subsection, if a nonparticipating physician or supplier provides the screening to an individual entitled to benefits under this part, the physician or supplier may not charge the individual more than the limiting charge (as defined in subparagraph (B), or, if applicable and if less, as defined in subsection (b)(5)(B)).

"(B) LIMITING CHARGE DEFINED.—In subparagraph (A), the term 'limiting charge' means, with respect to screening mammography performed—

"(i) in 1990, 125 percent of the limit established under paragraph (4),

"(ii) in 1991, 120 percent of the limit established under paragraph (4), and

"(iii) after 1991, 115 percent of the limit established under paragraph (4).

"(C) ENFORCEMENT.—If a physician or supplier knowing and willfully imposes a charge in violation of subparagraph (A), the Secretary may apply sanctions against such physician or supplier in accordance with section 1842(j)(2).".

(c) CERTIFICATION OF SCREENING MAMMOGRAPHY QUALITY STANDARDS.—

(1) Section 1863 (42 U.S.C. 1395z) is amended by inserting "or whether screening mammography meets the standards established under section 1834(e)(3)," after "1832(a)(2)(F)(i),".

(2) The first sentence of section 1864(a) (42 U.S.C. 1395aa(a)) is amended by inserting before the period the following: ", or whether screening mammography meets the standards established under section 1834(e)(3)".

(3) Section 1865(a) (42 U.S.C. 1395bb(a)) is amended by inserting "1834(e)(3)," after "1832(a)(2)(F)(i),".

(d) CONFORMING AMENDMENTS.—

(1) Section 1833(a)(2)(E) (42 U.S.C. 1395l(a)(2)(E)) is amended by inserting ", but excluding screening mammography" after "imaging services".

(2) Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (A), by striking "subparagraph (B), (C), (D), or (E)" and inserting "a succeeding subparagraph",

(ii) in subparagraph (D), by striking "and" at the end,

(iii) in subparagraph (E), by striking the semicolon at the end and inserting ", and", and

(iv) by adding at the end the following new subparagraph:

"(F) in the case of screening mammography, which is performed more frequently than is covered under section 1834(e)(2) or which does not meet the standards established under section 1834(e)(3);"; and

(B) in paragraph (7), by inserting "or under paragraph (1)(F)" after "(1)(B)".

(3) Sections 1864(a), 1865(a), 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) (42 U.S.C. 1395aa(a), 1395bb(a), 1396a(a)(9)(C), 1396n(a)(1)(B)(ii)(I)) are each amended by striking "paragraphs (13) and (14)" and inserting "paragraphs (14) and (15)".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to screening mammography performed on or after January 1, 1990. Paragraph (5) of section 1834(e) of the Social Security Act shall only apply until such time as the Secretary of Health and Human Services implements the physician fee schedules based on relative value scale developed under section 1845(e) of such Act.

(f) REPORTS.—

(1) The Physician Payment Review Commission shall study and report, by July 1, 1989, to the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate concerning the cost of providing screening mammography in a variety of settings and at different volume levels.

(2) The Comptroller General shall study and report, by July 1, 1989, to the Committees specified in paragraph (1) concerning the quality of care of screening mammography in a variety of settings.

SEC. 205. IN-HOME CARE FOR CERTAIN CHRONICALLY DEPENDENT INDIVIDUALS.

(a) IN GENERAL.—Section 1832(a) (42 U.S.C. 1395k(a)) is amended—

(1) in paragraph (2)(A)—

(A) by inserting "(i)" after "(A)", and

(B) by inserting before the semicolon at the end the following: ", and (ii) in-home care for a chronically dependent individual for up to 80 hours in any 12-month period described in section 1861(ll)(4), but not to exceed 80 hours in any calendar year;"; and

(2) by adding at the end the following new sentence:

"In the case of in-home care (described in paragraph (2)(A)(ii)) provided to a chronically dependent individual on any day, such care provided for 3 hours or less on the day shall be counted (for purposes of the limitation in such paragraph) as 3 hours of such care.".

(b) IN-HOME CARE FOR CHRONICALLY DEPENDENT INDIVIDUAL DEFINED.—Section 1861 (42 U.S.C. 1395x), as amended by section 204(a)(2), is amended by adding at the end the following new subsection:

"In-Home Care; Chronically Dependent Individual

"(ll)(1) The term 'in-home care' means the following items and services furnished, under the supervision of a registered professional nurse, to a chronically dependent individual (as defined in paragraph (2)) during the period described in paragraph (4) by a home health agency or by others under arrangements with them made by such agency in a place of residence used as such individual's home:

"(A) Services of a homemaker/home health aide (who has successfully completed a training program approved by the Secretary).

"(B) Personal care services.

"(C) Nursing care provided by a licensed professional nurse.

"(2) The term 'chronically dependent individual' means an individual who—

"(A) is dependent on a daily basis on a primary caregiver who is living with the individual and is assisting the individual without monetary compensation in the performance of at least 2 of the activities of daily living (described in paragraph (3)), and

"(B) without such assistance could not perform such activities of daily living.

"(3) The 'activities of daily living', referred to in paragraph (2), are as follows:

"(i) Eating.

"(ii) Bathing.

"(iii) Dressing.

"(iv) Toileting.

"(v) Transferring in and out of a bed or in and out of a chair.

"(4) The 12-month period described in this paragraph is the 1-year period beginning on the date that the Secretary determines that a chronically dependent individual either—

"(A) has become entitled to benefits under section 1833(c) (relating to having incurred out-of-pocket part B cost sharing equal to the part B catastrophic limit), or

"(B) has become entitled to have payments made for covered outpatient drugs under section 1834(c).

In the case of an individual who qualifies under subparagraph (A) or (B) within 12 months after previously qualifying, the subsequent qualification shall begin a new 12-month period under this paragraph. In the case of an individual enrolled in a buy-out plan (as defined in section 1833(c)(5)(D)) or a drug buy-out plan (as defined in section 1834(c)(6)(D)), the Secretary shall establish such procedures as may be appropriate to identify individuals who are deemed to be described in subparagraph (A) or (B), respectively, for purposes of the provision of in-home care under the plan.

(c) PAYMENT.—Section 1833(a) (42 U.S.C. 1395l(a)) is amended—

(1) in paragraph (2), by inserting "(A)(ii)," after "subparagraphs" the first place it appears,

(2) in paragraph (3), by striking "(D)" and inserting "(A)(ii), (D),", and

(3) by adding at the end the following:

"Payment for in-home care for chronically dependent individuals shall be paid on the basis of an hour of such care provided. In applying paragraph (2) in the case of an organization receiving payment under clause (A) of paragraph (1) or under a reasonable cost reimbursement contract under section 1876 and providing coverage of in-home care, the Secretary shall provide for an appropriate adjustment in the payment amounts otherwise made to reflect the aggregate increase in payments that would otherwise be made with respect to enrollees in the organization if payments were made other than under such clause or such a contract if payments were to be made on an individual-by-individual basis.".

(d) CERTIFICATION.—Section 1835(a)(2) (42 U.S.C. 1395n(a)(2)), as amended by section 203(d), is amended—

(1) by striking "and" at the end of subparagraph (F);

(2) by striking the period at the end of subparagraph (G) and inserting in lieu thereof "; and"; and

(3) by inserting after subparagraph (G) the following new subparagraph:

"(H) in the case of in-home care provided to a chronically dependent individual during a 12-month period, the individual was a chronically dependent individual during the 3-month period immediately preceding the beginning of the 12-month period.".

(e) STANDARDS FOR UTILIZATION.—

(1) Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 204(d)(2), is amended—

(A) in paragraph (1)—

(i) by striking "and" at the end of subparagraph (E),

(ii) by adding "and" at the end of subparagraph (F), and

(iv) by adding at the end the following new subparagraph:

"(G) in the case of in-home care for chronically dependent individuals, which is not reasonable and necessary to assure the health and condition of the individual is maintained in the individual's noninstitutional residence;"; and

(B) in paragraph (6), by inserting "and except, in the case of in-home care, as is otherwise permitted under paragraph (1)(F)" after "paragraph (1)(C)".

(2) The Secretary of Health and Human Services shall take appropriate efforts to assure the quality, and provide for appropriate utilization of, in-home care for chronically dependent individuals under the amendments made by this section.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1990.

(g) STUDY OF ALTERNATIVE OUT-OF-HOME SERVICES.—The Secretary of Health and Human Services shall study, and report to Congress, not later than 18 months after the date of the enactment of this Act, on the advisability of providing, to chronically dependent individuals eligible for in-home care under the amendments made by this section, out-of-home services (such as adult day care services or nursing facility services) as alternative services to in-home care.

SEC. 206. EXTENDING HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1861(m) (42 U.S.C. 1395x(m)) is amended by adding at the end the following new sentence: "For purposes of paragraphs (1) and (4) and sections 1814(a)(2)(C) and 1835(a)(2)(A), nursing care and home health aide services shall be considered to be provided or needed on an 'intermittent' basis if they are provided or needed less than 7 days each week and, in the case they are provided or needed for 7 days each week, if they are provided or needed for a period of up to 38 consecutive days.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished in cases of initial periods of home health services beginning on or after January 1, 1990.

SEC. 207. RESEARCH ON LONG-TERM CARE SERVICES FOR MEDICARE BENEFICIARIES.

(a) IN GENERAL.—The Secretary of Health and Human Services, from the funds appropriated under subsection (b), shall provide for research on issues relating to the delivery and financing of long-term care services for medicare beneficiaries. Such research shall include research into at least the following areas:

(1) The financial characteristics of medicare beneficiaries who receive or need long-term care services, including whether such beneficiaries are eligible for medicaid benefits for such services.

(2) How the financial and other characteristics of medicare beneficiaries affect their utilization of institutional and noninstitutional long-term care services.

(3) How relatives of medicare beneficiaries are affected financially and in other ways because the beneficiaries require or receive long-term care services.

(4) The quality of long-term care services (in community-based and custodial settings) and how the provision of long-term care services may reduce expenditures for acute health care services.

(5) The effectiveness of, and need for, State and Federal consumer protections which assure adequate access to and protect the rights of medicare beneficiaries who are provided long-term care services (other than in a nursing facility).

(b) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, in equal parts from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, $5,000,000 for each of fiscal years 1989, 1990, 1991, 1992, and 1993 to carry out the research described in subsection (a).

(c) LONG-TERM CARE SERVICES DEFINED.—In this section, the term "long-term care services" includes nursing home care, home care, community-based services, and custodial care.

(d) REPORTS.—The Secretary of Health and Human Services shall submit interim reports by December 1, 1990, and by December 1, 1992, and a final report by June 1, 1994, concerning the demonstration projects conducted under this section.

SEC. 208. STUDY OF ADULT DAY CARE SERVICES.

(a) SURVEY OF CURRENT ADULT DAY CARE SERVICES.—The Secretary of Health and Human Services shall conduct a survey of adult day care services in the United States to collect information concerning—

(1) the scope of such services and the extent of their availability;

(2) the characteristics of entities providing such services;

(3) licensure, certification, and other quality standards that are applied to those providing such services;

(4) the cost and financing of such services; and

(5) the characteristics of the people who use such services.

(b) REPORT.—The Secretary shall report to Congress, by not later than 1 year after the date of the enactment of this Act, on the information collected in the survey. Based on such information, the Secretary shall include in the report recommendations concerning appropriate standards for coverage of adult day care services under

medicare, including defining chronically dependent individuals, defining services included in adult day care services, establishing qualifications of providers of adult day care services, and establishing a reimbursement mechanism.

(c) ADULT DAY CARE SERVICES DEFINED.—In this section, the term "adult day care services" means medical or social services provided in an organized nonresidential setting to chronically impaired individuals who are not inpatients in a medical institution.

Subtitle B—Medicare Part B Monthly Premium Financing

SEC. 211. ADJUSTMENT IN MEDICARE PART B PREMIUM.

(a) IN GENERAL.—Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following new subsection:

"(g)(1)(A) Except as provided in this paragraph, paragraphs (4) and (5), and subsections (b) and (f), the monthly premium for each individual enrolled under this part otherwise determined, without regard to this subsection, shall be increased by the sum of the catastrophic coverage monthly premium and the prescription drug monthly premium for months in the year determined under the following table (for months occurring in 1989 through 1993) or determined in accordance with paragraphs (2) and (3) (for months after December 1993):

"In the case of:	*The catastrophic coverage monthly premium is:*	*The prescription drug monthly premium is:*
1989	*$4.00*	*0*
1990	*$4.90*	*0*
1991	*$5.46*	*$1.94*
1992	*$6.75*	*$2.45*
1993	*$7.18*	*$3.02*

"(B)(i) Except as provided in subparagraph (C), if the amount of the supplemental premium rate otherwise determined under section 59B of the Internal Revenue Code of 1986 for taxable years beginning in a calendar year is increased as a result of subsection (e)(2)(A)(i) of such section or is reduced as a result of subsection (e)(2)(A)(ii) of such section, the monthly premium increase otherwise determined under this paragraph shall be reduced or increased, respectively, by an amount equal to—

"(I) $\frac{1}{12}$th of the excess or shortfall, respectively, determined under clause (ii) for the year, as adjusted under clause (iv), divided by

"(II) the average number of individuals covered under this part during the preceding year.

"(ii) The excess or shortfall determined under this clause for a year is the excess or shortfall, determined by the Secretary of the Treasury, of—

"(I) the total amount of the supplemental premiums imposed under section 59B of the Internal Revenue Code of 1986 in the 2nd preceding year, over

"(II) the total amount of such premiums which would have been imposed in such year if the supplemental premium rate under such section had been increased by the shortfall rate, or decreased by the excess rate, described in clause (iii).

"(iii) The excess rate or shortfall rate under this clause for a year is the excess or shortfall of—

"(I) the supplemental premium rate established under section 59B of the Internal Revenue Code of 1986 for taxable years beginning in the year, and

"(II) the amount of such supplemental rate if determined without regard to subsection (e)(2)(A) of such section.

"(iv) The amount determined under clause (i)(I) for a year shall be increased by the percentage by which the per capita catastrophic coverage premium liability (as determined in section 59B(e)(3)(D)(ii) of the Internal Revenue Code of 1986) for the second preceding year exceeds such liability for the fourth preceding year (determined as if the catastrophic coverage premium rate for the second preceding calendar year were the same as the rate in effect for the fourth preceding calendar year).

"(C) In no event shall the monthly premium increase in effect under this paragraph for months in a year after 1993 be less than the monthly premium increase in effect under this paragraph for months in the preceding year.

"(D) If subparagraph (B) or subparagraph (C), or both, affects the increase in the monthly premium determined under this paragraph for a year, the increase in the monthly premium determined after the application of such subparagraph or subparagraphs shall be allocated between the catastrophic coverage monthly premium and the prescription drug monthly premium on the basis of the respective amounts of such premiums without regard to the application of either such subparagraph.

"(2)(A) In the case of months in a year after 1993, the catastrophic coverage monthly premium is the catastrophic coverage monthly premium (in effect under paragraph (1) or this paragraph for months in the preceding year, determined without regard to paragraph (1)(B) or (1)(C)) adjusted by the percentage determined under subparagraph (B) for the year.

"(B) The percentage determined under this subparagraph for a year shall be the sum of—

"(i) the outlay-premium percentage, and

"(ii) the reserve account percentage.

For purposes of the preceding sentence, negative percentages shall be taken into account as negatives.

"(C)(i) Except as provided in clause (ii), the outlay-premium percentage for any year is the percentage by which—

"(I) the per capita catastrophic outlays in the 2nd preceding year exceeds

"(II) such outlays in the 3rd preceding calendar year.

If there is no excess, this clause shall be applied by substituting 'is less than' for 'exceeds' and the percentage determined with such substitution shall be taken into account as a negative percentage.

"(ii) If—

"(I) the percentage increase in the CPI for the 12-month period ending with May of the preceding calendar year, exceeds (or is less than)

"(II) such increase for the 12-month period ending with May of the 2nd preceding calendar year,

by at least 1 percentage point, the percentage determined under clause (i) for any year shall be adjusted up (or down, respectively) by ½ of the amount by which such excess (or shortage, respectively) exceeds 1 percent.

"(D)(i) The reserve account percentage for any calendar year is the percentage which the premium change determined under clause (ii) is of the catastrophic coverage monthly premium in effect under paragraph (1) or this paragraph for the preceding year (determined without regard to paragraph (1)(B) or (1)(C)). If there is an excess determined under clause (iii), the percentage determined under the preceding sentence shall be taken into account as a negative percentage.

"(ii) The premium change determined under this clause for any year is the adjustment in the catastrophic coverage monthly premium (otherwise in effect for the 2nd preceding year) which the Secretary determines would have resulted in an aggregate increase (or decrease) in the premiums imposed by this subsection for such year equal to 37 percent of the shortfall or excess determined under clause (iii) for the calendar year.

"(iii) The shortfall (or excess) determined under this clause for any year is the amount by which—

"(I) 20 percent of the outlays during the 2nd preceding calendar year from the Medicare Catastrophic Coverage Account created under section 1841B, exceeds (or is less than)

"(II) the balance in such Account as of the close of such 2nd preceding calendar year (determined by taking into account previous premium increases by reason of the reserve account percentage under this paragraph or section 59B(e) of the Internal Revenue Code of 1986 which have not been credited into such Account).

"(3) In the case of months in a year after 1993, the prescription drug monthly premium shall be determined under rules similar to the rules of paragraph (2); except that—

"(A) in determining the prescription drug monthly premium for any month in a year before 1998, the following percentages shall be substituted for 20 percent in paragraph (2)(D)(iii)(I):

"In the case of year:	*The percentage is:*
1994	*75*
1995	*50*
1996	*25*
1997	*25;*

"(B) no adjustment by reason of the outlay-premium percentage shall be made for any calendar year before 1998;

"(C) any reference to the Medicare Catastrophic Coverage Account shall be treated as a reference to the Federal Catastrophic Drug Insurance Trust Fund, and

"(D) any reference to the catastrophic coverage monthly premium shall be treated as a reference to the prescription drug monthly premium.

"(4)(A) In the case of an individual who is a resident of Puerto Rico or who is a resident of another U.S. commonwealth or territory during a month, instead of the premium increase provided under paragraph (1), subject to subsection (b), the monthly premium for each individual enrolled under this part otherwise determined, without regard to this subsection, shall be increased by the sum of—

"(i) the catastrophic coverage monthly premium determined under subparagraph (B) for such resident for the year, and—

"(ii) the prescription drug monthly premium determined under subparagraph (C) for the resident for the year.

"(B) The catastrophic coverage monthly premium for months—

"(i) in 1989 is $1.30 for a resident of Puerto Rico and $2.10 for a resident of another U.S. commonwealth or territory;

"(ii) in 1990 is $3.56 for a resident of Puerto Rico and $5.78 for a resident of another U.S. commonwealth or territory; and

"(iii) in a subsequent year, with respect to a resident of Puerto Rico or a resident of another U.S. commonwealth or territory, is the catastrophic coverage monthly premium established under this subparagraph for the preceding year with respect to such a resident increased by the same percentage (estimated by the Secretary in September of that preceding year) by which—

"(I) the per capita catastrophic outlays for the year, will exceed

"(II) the per capita catastrophic outlays for that preceding year.

"(C) The prescription drug monthly premium for months—

"(i) in 1990 is $0.14 for a resident of Puerto Rico and $0.22 for a resident of another U.S. commonwealth or territory;

"(ii) in 1991 is $1.21 for a resident of Puerto Rico and $1.93 for a resident of another U.S. commonwealth or territory; and

"(iii) in a subsequent year, with respect to a resident of Puerto Rico or a resident of another U.S. commonwealth or territory, is the prescription drug monthly premium established under this subparagraph for the preceding year with respect to such a resident increased by the same percentage (estimated by the Secretary in September of that preceding year) by which—

"(I) the per capita prescription drug outlays for the year, will exceed

"(II) the per capita prescription drug outlays for that preceding year.

"(5)(A) In the case of a part B only individual (as defined in paragraph (8)(F)) during a month, instead of the premium increase provided under paragraph (1), subject to subsection (b), the monthly premium otherwise determined, without regard to this subsection, shall be increased by the sum of—

"(i) the catastrophic coverage monthly premium determined under subparagraph (B) for the year, and—

"(ii) the prescription drug monthly premium determined under subparagraph (C) for the year.

"(B) The catastrophic coverage monthly premium for months—

"(i) in 1990 is $8.57, and

"(ii) in a subsequent year is 1/12th of the average actuarial expenses that the Secretary estimates (during September before the year) will be incurred during the year for benefits and administration costs (other than benefits and costs attributable to part A) for which outlays may be made from the Medicare Catastrophic Coverage Account.

"(C) The prescription drug monthly premium for months—

"(i) in 1990 is $0.53,

"(ii) in 1991 is $4.61, and

"(iii) a subsequent year is 1/12th of the average actuarial expenses that the Secretary estimates (during September before the year) will be incurred during the year for benefits and administration costs for which outlays may be made from the Federal Catastrophic Drug Insurance Trust Fund.

"(6)(A) If any premium increase for a month under this subsection is not a multiple of 10 cents, the Secretary shall round the increase to the nearest multiple of 10 cents.

"(B) If the Secretary so rounds the premium increase, the amount of such increase shall be allocated between the catastrophic coverage monthly premium and the prescription drug monthly premium on the basis of the respective amounts of such premiums without regard to the application of subparagraph (A).

"(7)(A) The Secretary and the Secretary of the Treasury shall jointly—

"(i) publish in the Federal Register by not later than July 1 of each year (beginning with 1993) a proposed regulation to establish premium increases under this subsection for months in the following year,

"(ii) report to Congress, by not later than September 1 of such year, on the final premiums to be published under clause (iii), and

"(iii) publish in the Federal Register, during the last 3 days of September of each such year, a final regulation establishing monthly premiums under this subsection for months in the following year.

"(B) The Secretary shall report to Congress, in 1993, respecting the appropriateness of the level of premium increases established under paragraph (4) for residents of Puerto Rico and of other U.S. commonwealths and territories.

"(8) For purposes of this subsection:

"(A) The term 'per capita catastrophic outlays' means, with respect to any year, the amount (as determined by the Secretary) equal to—

"(i) the outlays during such year from the Medicare Catastrophic Coverage Account, divided by

"(ii) the average number of individuals entitled to receive benefits under part A during such year.

"(B) The term 'per capita prescription drug outlays' means, with respect to any year, the amount (as determined by the Secretary) equal to—

"(i) the outlays during such year from the Federal Catastrophic Drug Insurance Trust Fund, divided by

"(ii) the average number of individuals entitled to receive benefits under part A during such year.

"(C) The percentage increase in the CPI for any 12-month period shall be the percentage by which the Consumer Price Index (as defined in section 1(f)(5) of the Internal Revenue Code of 1986) for the last month of such period exceeds such Index for the last month of the preceding 12-month period.

"(D) The term 'Medicare Catastrophic Coverage Account' refers to such Account as created under section 1841B.

"(E) The term 'U.S. commonwealth or territory' means Puerto Rico, the United States Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands.

"(E) The term 'part B only individual' means, with respect to a month, an individual who—

"(i) is not a resident of a U.S. commonwealth or territory (as defined in subparagraph (D)) during the month,

"(ii) is entitled to benefits under this part, and

"(iii) is not entitled to (or, on application without payment of an additional premium, would not be entitled to) benefits under part A or is entitled to benefits under such part only because of payment of a premium under section 1818.".

(b) EXTENSION OF HOLD-HARMLESS PROVISION.—Subsection (f) of section 1839 is amended to read as follows:

"(f) For any calendar year after 1988, if an individual is entitled to monthly benefits under section 202 or 223 or to a monthly annuity under section 3(a), 4(a), or 4(f) of the Railroad Retirement Act of 1974 for November and December of the preceding year, and if the monthly premium of the individual under this section for December and for January is deducted from those benefits under section 1840(a)(1) or section 1840(b)(1), the monthly premium otherwise determined under this section for an individual for that year shall not be increased, pursuant to this subsection, to the extent that such increase would reduce the amount of benefits payable to that individual for that January below the amount of benefits payable to that individual for that December (after the deduction of the premium under this section). For purposes of this subsection, retroactive adjustments or payments and deductions on account of work shall not be taken into account in determining the monthly benefits to which an individual is entitled under section 202 or 223 or under the Railroad Retirement Act of 1974.".

(c) CONFORMING AMENDMENTS.—

(1) Section 1839 (42 U.S.C. 1395r) is amended—

(A) in the second sentence of subsections (a)(1) and (a)(4), by inserting "(other than costs relating to the amendments made by the Medicare Catastrophic Coverage Act of 1988)" before the period;

(B) by inserting before the period at the end of the last sentence of subsections (a)(1) and (a)(4) the following: ", but shall not take into account any amounts in the Trust Fund that may be attributable to receipts or outlays relating to the Medicare Catastrophic Coverage Account";

(C) in subsections (a)(2), by striking "and (e)" and inserting ", (e), and (g)";

(D) in subsection (a)(3), by striking "subsection (e)" and inserting "subsections (e) and (g)";

(E) in subsection (b), by striking "determined under subsection (a) or (e)" and inserting "otherwise determined under this section (without regard to subsections (f) and (g)(6))"; and

(F) in subsection (e)(1), by inserting "except as provided in subsection (g)," after "subsection (a)".

(2) Section 1844(a) (42 U.S.C. 1395w(a)(1)) is amended by adding at the end the following:

"In computing the amount of aggregate premiums and premiums per enrollee under paragraph (1), there shall not be taken into account premiums attributable to section 1839(g) or section 59B of the Internal Revenue Code of 1986.".

(3) Section 1876(a)(5) (42 U.S.C. 1395ff(a)(5)) is amended—

(A) by striking "and the Federal Supplementary Medical Insurance Trust Fund" and inserting ", the Federal Supplementary Medical Insurance Trust Fund, and the Federal Catastrophic Drug Insurance Trust Fund", and

(B) by amending the second sentence to read as follows: "The portion of that payment to the organization for a month to be paid by each trust fund shall be determined as follows:

"(A) In regard to expenditures by eligible organizations having risk-sharing contracts, the allocation shall be determined each year by the Secretary based on the relative weight that benefits from each fund contribute to the adjusted average per capita cost.

"(B) In regard to expenditures by eligible organizations operating under a reasonable cost reimbursement contract, the initial allocation shall be based on the plan's most recent budget, such allocation to be adjusted, as needed, after cost settlement to reflect the distribution of actual expenditures.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply (except as otherwise specified in such amendments) to monthly premiums for months beginning with January 1989.

SEC. 212. ESTABLISHMENT OF FEDERAL CATASTROPHIC DRUG INSURANCE TRUST FUND; FUND TRANSFERS.

(a) IN GENERAL.—Part B of title XVIII is amended by inserting after section 1841 the following new section:

"FEDERAL CATASTROPHIC DRUG INSURANCE TRUST FUND

"SEC. 1841A. (a)(1) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Catastrophic Drug Insurance Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1) and amounts transferred to it in accordance with section 1841(j) or under paragraph (2).

"(2) There are hereby appropriated to the Trust Fund amounts equivalent to 100 percent of the supplemental premiums imposed by section 59B of the Internal Revenue Code of 1986 which are attributable to the prescription drug rate. The amounts appropriated by the preceding sentence shall be transferred from time to time (not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of

estimates by the Secretary of the Treasury of the premiums, specified in the preceding sentence, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the premiums specified in such sentence. At the close of each year, the transfers under this subsection shall reflect all premiums paid or deposited (as specified in this subsection) into the Treasury in the year.

"(b) The provisions of subsections (b) through (i) of section 1841 shall apply to the Trust Fund in the same manner as they apply to the Federal Supplementary Medical Insurance Trust Fund.

"(c) Notwithstanding any other provision of this title, all payments under this part on or after January 1, 1990, for benefits and administrative costs relating to covered outpatient drugs shall be made from the Trust Fund.

"(d)(1) The Secretary of the Treasury, in consultation with the Board of Trustees of the Trust Fund, shall publish in the Federal Register—

"(A) not later than July 1 of each year (beginning with 1992), information on—

"(i) the outlays made from the Trust Fund in the preceding year, and

"(ii) the balance in the Trust Fund as of the close of the preceding year; and

"(B) during the last 3 days of September of each such year, the prescription drug monthly premiums to be established under section 1839(g) for months in the succeeding year.

"(2) The Secretary shall report to Congress, not later than July 1 of each year (beginning with 1992), respecting the distribution of outlays from the Trust Fund in the previous year among major spending categories. The Comptroller General shall report, not later than September 1 of each year, to Congress concerning the completeness and accuracy of the Secretary's report under the previous sentence and of the premiums established under section 1839(g) and under section 59B of the Internal Revenue Code of 1986.

"(e) In this part, with respect to the Trust Fund and the Medicare Catastrophic Coverage Account, the terms 'outlays' and 'receipts' mean, with respect to a quarter or other period, gross outlays and receipts, as such terms are employed in the 'Monthly Treasury Statement of Receipts and Outlays of the United States Government (MTS)', as published by the Department of the Treasury, for months in such quarter or other period.".

(b) TRANSFERS OF CERTAIN PREMIUMS.—

(1) TRANSFER OF FLAT PRESCRIPTION DRUG PREMIUMS TO FEDERAL CATASTROPHIC DRUG INSURANCE TRUST FUND.—Section 1840 (42 U.S.C. 1395s) is amended by adding at the end the following new subsection:

"(i) Notwithstanding the previous provisions of this subsection, premiums collected under this part which are attributable to a prescription drug monthly premium established under section 1839(g) shall, instead of being transferred to (or being deposited to the credit of) the Federal Supplemental Medical Insurance Trust Fund, be transferred to (or deposited to the credit of) the Federal Catastrophic Drug Insurance Trust Fund.".

(2) TRANSFER OF SUPPLEMENTAL CATASTROPHIC COVERAGE PREMIUMS INTO THE SMI TRUST FUND.—Section 1841(a) (42 U.S.C. 1395t(a)) is amended by adding the following: "There are hereby appropriated to the Trust Fund amounts equivalent to 100 percent of the supplemental premiums imposed by section 59B of the Internal Revenue Code of 1986 which are attributable to the catastrophic coverage rate and which are not otherwise appropriated under section 1817A(a)(2) to the Federal Hospital Insurance Catastrophic Coverage Reserve Fund. The amounts appropriated by the preceding sentence shall be transferred from time to time (not less frequently than monthly) from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the premiums, specified in the preceding sentence, paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the premiums specified in such sentence. At the close of each year, the transfers under this subsection shall reflect all premiums under section 59B of the Internal Revenue Code of 1986 paid or deposited into the Treasury in the year.".

(c) CONFORMING AMENDMENTS.—

(1)(A) Section 201(g)(1)(A) (42 U.S.C. 401(g)(1)(A)) is amended by striking "and the Federal Supplementary Medical Insurance Trust Fund" and inserting ", Federal Supplementary Medical Insurance Trust Fund, and the Federal Catastrophic Drug Insurance Trust Fund".

(B) Section 201(i)(1) (42 U.S.C. 401(i)(1)) is amended by striking "and the Federal Supplementary Medical Insurance Trust Fund" and inserting ", Federal Hospital Insurance Catastrophic Coverage Reserve Fund, Federal Supplementary Medical Insurance Trust Fund, and the Federal Catastrophic Drug Insurance Trust Fund".

(2) Section 1833(a) (42 U.S.C. 1395l(a)) is amended, in the matter before paragraph (1), by inserting "or, as provided in section 1841A(c), from the Federal Catastrophic Drug Insurance Trust Fund" after "Medical Insurance Trust Fund".

(3) Section 1817(b) (42 U.S.C. 1395i(b)) is amended by inserting after the sixth sentence the following: "Such report shall also identify (and treat separately) those outlays from the Trust Fund which are also outlays from the Medicare Catastrophic Coverage Account created under section 1841B and those outlays for which there are amounts transferred into the Federal Hospital Insurance Catastrophic Coverage Reserve Fund.".

(4) Section 1841(b) (42 U.S.C. 1395t(b)) is amended by inserting after the sixth sentence the following: "Such report shall also identify (and treat separately) those receipts and outlays in the Trust Fund which are also receipts and outlays in the Medicare Catastrophic Coverage Account created under section 1841B.".

SEC. 213. CREATION OF MEDICARE CATASTROPHIC COVERAGE ACCOUNT.

(a) IN GENERAL.—Part B of title XVIII is amended by inserting after section 1841A, as inserted by section 212, the following new section:

"MEDICARE CATASTROPHIC COVERAGE ACCOUNT

"SEC. 1841B. (a) For purposes of carrying out certain provisions of this title, and section 59B of the Internal Revenue Code of 1986, there is hereby created on the books of the Treasury of the United States an account to be known as the 'Medicare Catastrophic Coverage Account' (in this section referred to as the 'Account'), to be maintained by the Secretary of the Treasury in consultation with the Boards of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. No funds shall actually be transferred into or paid out of the Account, but, for other purposes of this part and for purposes of section 59B of the Internal Revenue Code of 1986, amounts credited to the Account shall be considered receipts of the Account and amounts debited to account shall be considered outlays from the Account.

"(b)(1) The Account shall be—

"(A) credited for receipts of the Federal Supplementary Medical Insurance Trust Fund attributable to the portion of supplemental premiums under section 59B of the Internal Revenue Code of 1986, and the premiums under section 1839(g), attributable to the catastrophic coverage premium rate or catastrophic coverage monthly premium,

"(B) credited for receipts of the Federal Hospital Insurance Catastrophic Coverage Reserve Fund, and

"(C) debited for outlays made under this title that are attributable to the amendments made by the Medicare Catastrophic Coverage Act of 1988 (other than outlays relating to covered outpatient drugs and related administrative costs).

"(2) In addition, the Account shall be—

"(A) credited with interest (at the rate used for purposes of the Federal Supplementary Medical Insurance Trust Fund) on any positive average balance maintained in the Account in a calendar quarter, and

"(A) debited with interest (at the rate used for purposes of the Federal Supplementary Medical Insurance Trust Fund) on any negative average balance maintained in the Account in a calendar quarter.

"(3) Credits and debits under this subsection shall be made as of the last date of each month based upon receipts and outlays occurring during the month, as estimated by the Secretary and the Secretary of the Treasury.

"(4) The Account shall also identify (and treat separately) those credits and debits in the Account which are also receipts and outlays in the Federal Supplementary Medical Insurance Trust Fund, those receipts which are also receipts of the Federal Hospital Insurance Catastrophic Coverage Reserve Fund, and those outlays that are also outlays from the Federal Hospital Insurance Trust Fund.

"(c)(1) The Secretary of the Treasury shall publish in the Federal Register—

"(A) not later than July 1 of each year (beginning with 1990), information on—

"(i) the outlays made from the Account in the preceding year, and

"(ii) the balance in the Account as of the close of the preceding year; and

"(B) during the last 3 days of September of each such year, the catastrophic coverage monthly premiums to be established under section 1839(g) for months in the succeeding year.

"(2) The Secretary shall report to Congress, not later than July 1 of each year (beginning with 1990), respecting the distribution of outlays from the Account in the previous year among major spending categories. The Comptroller General shall report, not later than September 1 of each year, to Congress concerning the completeness and accuracy of the Secretary's report under the previous sentence and of the premiums established under section 1839(g) and under section 59B of the Internal Revenue Code of 1986.

"(d) The Secretary of the Treasury shall report to Congress in April of each year on the status of the Account created under this section.".

Subtitle C—Miscellaneous Provisions

SEC. 221. VOLUNTARY CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES.

(a) FREE-LOOK PERIOD.—Section 1882 (42 U.S.C. 1395ss) is amended—

(1) in subsection (b)(1)(B), by striking "and (3)" and inserting "through (4)", and

(2) in subsection (c)—

(A) by striking "and" at the end of paragraph (2),

(B) by striking the period at the end of paragraph (3) and inserting "; and", and

(C) by adding at the end thereof the following:

"(4) may, during a period of not less than 30 days after the policy is issued, be returned for a full refund of any premiums paid (without regard to the manner in which the purchase of the policy was solicited).".

(b) REPORTING OF INFORMATION RELATING TO LOSS RATIOS.—Section 1882(b)(1), as amended by subsection (a), is further amended—

(1) in subparagraph (C), by striking "(A) and (B)" and inserting "(A), (B), and (C)",

(2) by redesignating subparagraphs (C) and (D) as subparagraphs (D) and (E), respectively (D) as subparagraph (D), and

(3) by inserting after subparagraph (B) the following new subparagraph:

"(C) provides that—

"(i) information with respect to the actual ratio of benefits provided to premiums collected under such policies will be reported to the State on forms conforming to those developed by the National Association of Insurance Commissioners for such purpose, or

"(ii) such ratios will be monitored under the program in an alternative manner approved by the Secretary;".

(c) CONSUMER INFORMATION.—Section 1882(e) is amended—

(1) by inserting "(1)" after "(e)", and

(2) by adding at the end thereof the following:

"(2) The Secretary shall—

"(A) inform all individuals entitled to benefits under this title (and, to the extent feasible, individuals about to become so entitled) of—

"(i) the actions and practices that are subject to sanctions under subsection (d), and

"(ii) the manner in which they may report any such action or practice to an appropriate official of the Department of Health and Human Services (or to an appropriate State official), and

"(B) publish the toll-free telephone number for individuals to report suspected violations of the provisions of such subsection.

"(3) The Secretary shall provide individuals entitled to benefits under this title (and, to the extent feasible, individuals about to become so entitled) with a listing of the addresses and telephone numbers of State and Federal agencies and offices that provide information and assistance to individuals with respect to the selection of medicare supplemental policies.".

(d) REVISION OF MODEL STANDARDS; TRANSITION.—Section 1882 is further amended—

(1) in the third sentence of subsection (a), by striking "Such certification" and inserting "Subject to subsection (k)(3), such certification";

(2) in subsection (b), by striking "(for so long as" and inserting "(subject to subsection (k)(3), for so long as"; and

(3) by adding at the end thereof the following new subsections:

"(k)(1)(A) If, within the 90-day period beginning on the date of the enactment of this subsection, the National Association of Insurance Commissioners (in this subsection referred to as the 'Association') amends the NAIC Model Regulation adopted on June 6, 1979 (as it relates to medicare supplemental policies), with respect to matters such as minimum benefit standards, loss ratios, disclosure requirements, and replacement requirements and provisions otherwise necessary to reflect the changes in law made by the Medicare Catastrophic Coverage Act of 1988, subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the Model Regulation as amended by the Association in accordance with this paragraph (in this subsection and subsection (l) referred to as the 'amended NAIC Model Regulation').

"(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the amended NAIC Model Regulation or 1 year after the date the Association first adopts such amended Regulation.

"(2)(A) If the Association does not amend the NAIC Model Regulation within the 90-day period specified in paragraph (1)(A), the Secretary shall promulgate, not later than 60 days after the end of such period, Federal model standards (in this subsection and subsection (l) referred to as 'Federal model standards') for medicare supplemental policies to reflect the changes in law made by the Medicare Catastrophic Coverage Act of 1988, and subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified

in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to Federal model standards.

"(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the Federal model standards or 1 year after the date the Secretary first promulgates such standards.

"(3) Notwithstanding any other provision of this section (except as provided in subsection (l))—

"(A) no medicare supplemental policy may be certified by the Secretary pursuant to subsection (a),

"(B) no certification made pursuant to subsection (a) shall remain in effect, and

"(C) no State regulatory program shall be found to meet (or to continue to meet) the requirements of subsection (b)(1)(A),

unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set forth in the amended NAIC Model Regulation or the Federal model standards (as the case may be) by the date specified in paragraph (1)(B) or (2)(B) (as the case may be).

"(l)(1) Until the date specified in paragraph (3), in the case of a qualifying medicare supplemental policy described in paragraph (2) issued—

"(A) before January 1, 1989, the policy is deemed to remain in compliance with this section if the insurer issuing the policy complies with the NAIC Model Transition Regulation (including giving notices to subscribers and filing for premium adjustments with the State as described in section 5.B. of such Regulation) by January 1, 1989; or

"(B) on or after January 1, 1989, the policy is deemed to be in compliance with this section if the insurer issuing the policy complies with the NAIC Model Transition Regulation before the date of the sale of the policy.

"(2) In paragraph (1), the term 'qualifying medicare supplemental policy' means a medicare supplemental policy—

"(A) issued in a State which—

"(i) has not adopted standards equal to or more stringent than the NAIC Model Transition Regulation by January 1, 1989, and

"(ii) has not adopted standards equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards) by January 1, 1989; and

"(B) which has been issued in compliance with this section (as in effect on June 1, 1988).

"(3)(A) The date specified in this paragraph is the earlier of—

"(i) the first date a State adopts, after January 1, 1989, standards equal to or more stringent than the NAIC Model Transition Regulation or equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards), as the case may be, or

"(ii) the later of (I) the date specified in subsection (k)(1)(B) or (k)(2)(B) (as the case may be), or (II) the date specified in subparagraph (B).

"(B) In the case of a State which the Secretary identifies as—

"(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet standards described in subparagraph (A)(i), but

"(ii) having a legislature which is not scheduled to meet in 1989 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1989, and in which legislation described in clause (i) may be considered. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

"(4) In the case of a medicare supplemental policy in effect on January 1, 1989, and offered in a State which, as of such date—

"(A) has adopted standards equal to or more stringent than the amended NAIC Model Regulation (or Federal model standards), but

"(B) does not have in effect standards equal to or more stringent than the NAIC Model Transition Regulation (or otherwise requiring notice substantially the same as the notice required in section 5.B. of such Regulation),

the policy shall not be deemed to meet the standards in subsection (c) unless each individual who is entitled to benefits under this title and is a policyholder under such policy on January 1, 1989, is sent such a notice in any appropriate form by not later than January 31, 1989, that explains—

"(A) the improved benefits under this title contained in the Medicare Catastrophic Coverage Act of 1988, and

"(B) how these improvements affect the benefits contained in the policies and the premium for the policy.

"(5) In this subsection, the term 'NAIC Model Transition Regulation' refers to the standards contained in the 'Model Regulation to Implement Transitional Requirements for the Conversion of Medicare Supplement Insurance Benefits and Premiums to Conform to Medicare Program Revisions' (as adopted by the National Association of Insurance Commissioners in September 1987).

"(6) The Secretary shall report to the Congress in March 1989 and in July 1990 on actions States have taken in adopting standards equal to or more stringent than the NAIC Model Transition Regulation or the amended NAIC Model Regulation (or Federal model standards).".

(e) REQUIRED SUBMISSION OF ADVERTISING.—Section 1882(b) is further amended by adding at the end the following new paragraph:

"(3) Notwithstanding paragraph (1), a medicare supplemental policy offered in a State shall not be deemed to meet the standards and requirements set forth in subsection (c), with respect to an advertisement (whether through written, radio, or television medium) used (or, at a State's option, to be used) for the policy in the State, unless the entity issuing the policy provides a copy of each advertisement to the Commissioner of Insurance (or comparable officer identified by the Secretary) of that State for review or approval to the extent it may be required under State law.".

(f) APPOINTMENT OF SUPPLEMENTAL HEALTH INSURANCE PANEL MEMBERS.—Section 1882(b)(2)(A) is amended by striking "appointed by the President" and inserting "appointed by the Secretary".

(g) EFFECTIVE DATES.—

(1) Except as provided in paragraphs (2) and (3), the amendments made by this section shall take effect on the date of the enactment of this Act.

(2) The amendments made by subsections (a) and (b) shall become effective on the date specified in subsection (k)(1)(B) or (k)(2)(B) of section 1882 of the Social Security Act (as added by subsection (c) of this section).

(3) The amendment made by subsection (f) shall apply to medicare supplemental policies as of January 1, 1989, with respect to advertising used on or after such date.

(4) The Secretary of Health and Human Services shall provide for the reappointment of members to the Supplemental Health Insurance Panel (under section 1882(b)(2) of the Social Security Act) by not later than 90 days after the date of the enactment of this Act.

SEC. 222. ADJUSTMENT OF CONTRACTS WITH PREPAID HEALTH PLANS.

The Secretary of Health and Human Services shall—

(1) modify contracts under sections 1833(a)(1)(A) and 1876 of the Social Security Act, for portions of contract years occurring after December 31, 1988, to take into account the amendments made by this Act; and

(2) require such organizations to make appropriate adjustments (including adjustments in premiums and benefits) in the terms of their agreements with medicare beneficiaries to take into account such amendments.

The Secretary shall also provide for appropriate modifications of contracts with health maintenance organizations under section 1876(i)(2)(A) of the Social Security Act (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967, or under section 222(a) of the Social Security Amendments of 1972, for portions of contract years occurring after December 31, 1988, so as to apply to such organizations and contracts the requirements imposed by the amendments made by this Act upon an organization with a risk-sharing contract under section 1876 of the Social Security Act.

SEC. 223. MAILING OF NOTICE OF MEDICARE BENEFITS AND INFORMATION DESCRIBING PARTICIPATING PHYSICIAN PROGRAM.

(a) DISTRIBUTION OF NOTICES.—Title XVIII is amended by inserting after section 1803 the following new section:

"NOTICE OF MEDICARE BENEFITS

"SEC. 1804. The Secretary shall prepare (in consultation with groups representing the elderly and with health insurers) and provide for distribution of a notice containing—

"(1) a clear, simple explanation of the benefits available under this title and the major categories of health care for which benefits are not available under this title,

"(2) the limitations on payment (including deductibles and coinsurance amounts) that are imposed under this title, and

"(3) a description of the limited benefits for long-term care services available under this title and generally available under State plans approved under title XIX.

Such notice shall be mailed annually to individuals entitled to benefits under part A or part B of this title and when an individual applies for benefits under part A or enrolls under part B.".

(b) DISTRIBUTION OF INFORMATION DESCRIBING PARTICIPATING PHYSICIAN PROGRAM.—Section 1842(h)(5) (42 U.S.C. 1395u(h)(5)) is amended—

(1) by inserting "through an annual mailing" after "under this part",

(2) by striking the last sentence,

(3) by inserting "(A)" after "(5)", and

(4) by adding at the end the following new subparagraph:

"(B) The annual notice provided under subparagraph (A) shall include—

"(i) a description of the participation program,

"(ii) an explanation of the advantages to beneficiaries of obtaining covered services through a participating physician or supplier,

"(iii) an explanation of the assistance offered by carriers in obtaining the names of participating physicians and suppliers, and

"(iv) the toll-free telephone number under paragraph (2)(A) for inquiries concerning the program and for requests for free copies of appropriate directories.".

(c) REVISION OF EXPLANATION OF MEDICARE BENEFITS.—Section 1842(h)(7) (42 U.S.C. 1395u(h)(7)) is amended—

(1) in subparagraph (A)—

(A) by inserting "prominent" before "reminder", and

(B) by striking "), and" and inserting "and a clear statement of any amounts charged for the particular items or services on the claim involved above the amount recognized under this part),";

(2) in subparagraph (B), by striking the period at the end and inserting ", and"; and

(3) by adding at the end the following new subparagraph:

"(C) shall include (i) an offer of assistance to such an individual in obtaining the names of participating physicians of appropriate specialty and (ii) an offer to provide a free copy of the appropriate participating physician directory.".

(d) EFFECTIVE DATES.—

(1) The Secretary of Health and Human Services shall first distribute the notice required by the amendment made by subsection (a) not later than January 31, 1989.

(2) The amendments made by subsection (b) shall apply to annual notices beginning with 1989.

(3) The amendments made by subsection (c) shall first apply to explanations of benefits provided for items and services furnished on or after January 1, 1989.

SEC. 224. CHANGES IN CIVIL MONEY PENALTIES FOR CERTAIN PRACTICES OF HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.

Section 1876(i)(6)(B)(i) (42 U.S.C. 1395mm(i)(6)(B)(i)) is amended by adding at the end the following: "plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and return to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iv), $15,000 for each individual not enrolled as a result of the practice involved,".

TITLE III—PROVISIONS RELATING TO THE MEDICAID PROGRAM

SEC. 301. REQUIRING MEDICAID BUY-IN OF PREMIUMS AND COST-SHARING FOR INDIGENT MEDICARE BENEFICIARIES.

(a) REQUIREMENT.—

(1) Section 1902(a)(10)(E) (42 U.S.C. 1396a(a)(10)(E)) is amended by striking "at the option of a State, but".

(2) Section 1905(p)(1)(B) (42 U.S.C. 1396d(p)(1)(B)) is amended by striking "and the election of the State".

(b) PHASING-IN REQUIRED INCOME STANDARD TO 100 PERCENT OF POVERTY LEVEL.—Section 1905(p)(2)(A) (42 U.S.C. 1396d(p)(2)(A)) is amended—

(1) by striking "may not exceed a percentage (not more than 100 percent)" and inserting "shall be at least the percent provided under clause (ii) (but not more than 100 percent)",

(2) by inserting "(i)" after "(2)(A)", and

(3) by adding at the end the following new clause:

"(ii) Except as provided in clause (iii), the percent provided under this clause, with respect to eligibility for medical assistance on or after—

"(I) January 1, 1989, is 85 percent,
"(II) January 1, 1990, is 90 percent,
"(III) January 1, 1991, is 95 percent, and
"(IV) January 1, 1992, is 100 percent.

"(iii) In the case of a State which has elected treatment under section 1902(f) and which, as of January 1, 1987, used an income standard for individuals age 65 or older which was more restrictive than the income standard established under the supplemental security income program under title XVI, the percent provided under clause (ii), with respect to eligibility for medical assistance on or after—

"(I) January 1, 1989, is 80 percent,
"(II) January 1, 1990, is 85 percent,
"(III) January 1, 1991, is 90 percent,
"(IV) January 1, 1992, is 95 percent, and
"(V) January 1, 1993, is 100 percent.".

(c) RESOURCE STANDARD.—Section 1905(p) (42 U.S.C. 1396d(p)) is amended—

(1) in paragraph (1)(C), by striking "(2)(A)" and inserting "(2)";

(2) in paragraph (1)(D), by striking "(except as provided in paragraph (2)(B))" and inserting "twice"; and

(3) in paragraph (2)—

(A) in subparagraph (A), by striking "(2)(A)" and inserting "(2)", and

(B) by striking subparagraph (B).

(d) MEDICARE COVERAGE.—Section 1905(p) (42 U.S.C. 1396d(p)) is amended—

(1) in paragraph (3)(A), by striking "under part B and (if applicable) under section 1818" and inserting "under title XVIII (including under part B and, if applicable, under section 1818)";

(2) by amending subparagraphs (B) and (C) of paragraph (3) to read as follows:

"(B) Coinsurance under title XVIII (including coinsurance described in section 1813).

"(C) Subject to paragraph (4), deductibles established under title XVIII (including those described in section 1813, 1833(b), and section 1834(c)(1)).''; and

(3) by adding at the end the following new paragraph:

"(4) In a State which provides medical assistance for prescribed drugs under section 1905(a)(12), instead of providing to qualified medicare beneficiaries, under paragraph (3)(C), medicare cost-sharing with respect to the annual deductible for covered outpatient drugs under section 1834(c)(1), the State may provide to such beneficiaries, before charges for covered outpatient drugs for a year reach such deductible amount, benefits for prescribed drugs in the same amount, duration, and scope as the benefits made available under the State plan for individuals described in subsection (a)(10)(A)(i).''.

(e) CONFORMING AMENDMENTS.—

(1) Section 1843 (42 U.S.C. 1395v) is amended by inserting "or after 1988" in subsections (a), (g)(1), and (h)(1) after "during 1981".

(2) Section 1902 (42 U.S.C. 1396a) is amended—

(A) in subsection (a)(10)(A)(ii)(X), by striking "subject to subsection (m)(3),",

(B) in subsection (a)(10)(E), by striking "subject to subsection (m)(3),";

(C) in subsection (a)(17), by striking "(m)(4), and (m)(5)" and inserting "(m)(3), and (m)(4)", and

(D) in subsection (m), by striking paragraph (3) and by redesignating paragraphs (4) and (5) as paragraphs (3) and (4), respectively.

(3) The amendment made by paragraph (1) shall take effect on January 1, 1989, and the amendments made by paragraph (2) shall take effect on July 1, 1989.

(f) TECHNICAL AMENDMENT.—Effective as though included in the enactment of the Omnibus Budget Reconciliation Act of 1986, paragraph (2) of section 9403(g) of such Act is amended to read as follows:

"(2) PAYMENT OF MEDICARE COST-SHARING.—Section 1903(a)(1) (42 U.S.C. 1396b(a)(1)) is amended by inserting 'including expenditures for medicare cost-sharing and' before 'including expenditures.'.''.

(g) TREATMENT OF CERTAIN STATES.—

(1) STATES OPERATING UNDER DEMONSTRATION PROJECTS.—In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115(a) of the Social Security Act, the Secretary of Health and Human Services shall require the State to meet the requirement of section 1902(a)(10)(E) of the Social Security Act in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under title XIX of such Act.

(2) COMMONWEALTHS AND TERRITORIES.—Section 1905(p) (42 U.S.C. 1396d(p)), as amended by subsection (d)(3), is further amended by adding at the end the following new paragraph:

"(5) Notwithstanding any other provision of this title, in the case of a State (other than the 50 States and the District of Columbia)—

"(A) the requirement stated in section 1902(a)(10)(E) shall be optional, and

"(B) for purposes of paragraph (2)(A), the State may substitute for the percent provided under clause (ii) of such paragraph any percent.".

(h) EFFECTIVE DATE.—(1) The amendments made by this section apply (except as provided in subsections (e) and (f) and under paragraph (2)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after January 1, 1989, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date, with respect to medical assistance for—

(A) monthly premiums under title XVIII of such Act for months beginning with January 1989, and

(B) items and services furnished on and after January 1, 1989.

(2) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 302. COVERAGE AND PAYMENT FOR PREGNANT WOMEN AND INFANTS WITH INCOMES BELOW POVERTY LINE.

(a) PREGNANT WOMEN AND INFANTS UNDER AGE 1.—

(1) REQUIRING COVERAGE.—Section 1902(a)(10) (42 U.S.C. 1396a) is amended—

(A) in subparagraph (A)(i), by striking "or" at the end of subclause (II), by striking the semicolon in subclause (III) and inserting ", or", and by adding at the end the following new subclause:

"(IV) who are described in subparagraph (A) or (B) of subsection (l)(1) and whose family income does not exceed the minimum income level the State is required to establish under subsection (l)(2)(A) for such a family;";

(B) by amending subclause (IX) of subparagraph (A)(ii) to read as follows:

"(IX) who are described in subsection (l)(1) and are not described in clause (i)(IV);"; and

(C) in clause (VII) in the matter after and below subparagraph (E), by inserting "(A)(i)(IV) or" before "(A)(ii)(IX)".

(2) DESCRIPTION OF INDIVIDUALS REQUIRED TO BE COVERED.—Section 1902(l) (42 U.S.C. 1396a(l)) is amended—

(A) in paragraph (1)(C)—

(i) by inserting "at the option of the State," after "(C)", and

(ii) by striking "and" after "1983,"; and

(B) in paragraph (2)(A)—

(i) by striking "not more than 185 percent)" and inserting "(not less than the percentage provided under clause (ii) and not more than 185 percent)";

(ii) by inserting "(i)" after "(2)(A)"; and

(iii) by adding at the end the following new clause:

"(ii) Subject to clause (iii), the percentage provided under this clause, with respect to eligibility for medical assistance on or after—

"(I) July 1, 1989, is 75 percent, and

"(II) July 1, 1990, is 100 percent.

"(iii) In the case of a State which, as of the date of the enactment of this clause, has elected to provide, and provides, medical assistance to individuals described in this subsection or has enacted legislation authorizing, or appropriating funds, to provide such assistance to such individuals before July 1, 1989, the percentage provided under clause (ii) shall not be less than—

"(I) the percentage specified by the State in an amendment to its State plan (whether approved or not) as of the date of the enactment of this clause, or

"(II) if no such percentage is specified as of the date of the enactment of this clause, the percentage established under the State's authorizing legislation or provided for under the State's appropriations;

but in no case shall this clause require the percentage provided under clause (ii) to exceed 100 percent.".

(b) COVERAGE OF MEDICALLY NECESSARY SERVICES FOR INFANTS AND ASSURING ADEQUATE PAYMENT FOR INPATIENT HOSPITAL SERVICES FOR INFANTS IN DISPROPORTIONATE SHARE HOSPITALS.—

(1) COVERAGE OF MEDICALLY NECESSARY SERVICES FOR INFANTS.—Section 1902(a)(10) (42 U.S.C. 1396a(a)(10)) is amended, in the matter after and below subparagraph (E)—

(A) by striking "and" before "(IX)", and

(B) by inserting before the semicolon at the end the following: ", and (X) if the plan provides for any fixed durational limit on medical assistance for inpatient hospital services (whether or not such a limit varies by medical condition or diagnosis), the plan must establish exceptions to

such a limit for medically necessary inpatient hospital services furnished with respect to individuals under one year of age in a hospital defined under the State plan, pursuant to section 1923(a)(1)(A), as a disproportionate share hospital and subparagraph (B) (relating to comparability) shall not be construed as requiring such an exception for other individuals, services, or hospitals".

(2) ASSURING ADEQUATE PAYMENT FOR INPATIENT HOSPITAL SERVICES FOR INFANTS IN DISPROPORTIONATE SHARE HOSPITALS.—Section 1923(a)(2), as redesignated pursuant to the amendment made by section 411(k)(6)(B) of this Act, is amended by adding at the end the following new subparagraph:

"(C) If a State plan under this title provides for payments for inpatient hospital services on a prospective basis (whether per diem, per case, or otherwise), in order for the plan to be considered to have met such requirement of section 1902(a)(13)(A) as of July 1, 1989, the State must submit to the Secretary by not later than April 1, 1989, a State plan amendment that provides, in the case of hospitals defined by the State as disproportionate share hospitals under paragraph (1)(A), for an outlier adjustment in payment amounts for medically necessary inpatient hospital services provided on or after July 1, 1989, involving exceptionally high costs or exceptionally long lengths of stay for individuals under one year of age.".

(c) CERTAIN STATE PLAN REQUIREMENTS.—

(1) IN GENERAL.—Subsection (c) of section 1902 (42 U.S.C. 1396a) is amended to read as follows:

"(c) Notwithstanding subsection (b), the Secretary shall not approve any State plan for medical assistance if—

"(1) the State has in effect, under its plan established under part A of title IV, payment levels that are less than the payment levels in effect under such plan on May 1, 1988; or

"(2) the State requires individuals described in subsection (l)(1) to apply for benefits under such part as a condition of applying for, or receiving, medical assistance under this title.".

(2) ELIMINATING DUPLICATE REQUIREMENT.—Section 1902(l) (42 U.S.C. 1396a(l)) is amended by striking paragraph (4).

(3) MAINTENANCE OF EFFORT TO RECEIVE MEDICAL ASSISTANCE FOR OPTIONAL COVERAGE OF PREGNANT WOMEN AND CHILDREN.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended—

(A) by striking the period at the end of paragraph (8) and inserting "; or", and

(B) by inserting after paragraph (8) the following new paragraph:

"(9) with respect to any amount of medical assistance for pregnant women and children described in section 1902(a)(10)(A)(ii)(IX), if the State has in effect, under its plan established under part A of title IV, payment levels that are less than the payment levels in effect under such plan on July 1, 1987.".

(d) TREATMENT OF CERTAIN STATES AND TERRITORIES.—Section 1902(l) (42 U.S.C. 1396a(l)) is amended by adding at the end the following new paragraph:

"(4)(A) In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the

Secretary shall require the State to provide medical assistance for pregnant women and infants under age 1 described in subsection (a)(10)(A)(i)(IV) in the same manner as the State would be required to provide such assistance for such individuals if the State had in effect a plan approved under this title.

"(B) In the case of a State which is not one of the 50 States or the District of Columbia, the State need not meet the requirement of subsection (a)(10)(A)(i)(IV) and, for purposes of paragraph (2)(A), the State may substitute for the percentage provided under clause (ii) of such paragraph any percentage.".

(e) CONFORMING AMENDMENTS.—

(1) Section 1902(e)(6) (42 U.S.C. 1396a(e)(6)) is amended to read as follows:

"(6) At the option of a State, in the case of a pregnant woman described in subsection (a)(10) who, because of a change in income of the family of which she is a member, would not otherwise continue to be described in such subsection, the State plan may nonetheless treat the woman as being an individual described in subsection (a)(10)(A)(i)(IV) and subsection (l)(1)(A) without regard to such change of income through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends.".

(2) Section 1902(e)(7) (42 U.S.C. 1396a(e)(7)) is amended—

(A) by striking "If a State plan provides medical assistance for individuals under subsection (a)(10)(A)(ii)(IX), in" and inserting "In",

(B) by inserting "or paragraph (2) of section 1905(n)" after "subsection (l)(1)" the first place it appears, and

(C) by striking "subsection (a)(10)(A)(ii)(IX) and subsection (l)(1)" and inserting "such respective provision".

(3) Section 1902(l) (42 U.S.C. 1396a(l)) is amended—

(A) in the matter after and below subparagraph (C) of paragraph (1), by inserting "any of subclauses (I) through (III) of " after "who are not described in", and

(B) in paragraph (3), in the matter before subparagraph (A), by inserting "(a)(10)(A)(i)(IV) or" before "(a)(10)(A)(ii)(IX)".

(4) Section 1903(f)(4) (42 U.S.C. 1396b(f)(4)) is amended, in the matter before subparagraph (A), by inserting "1902(a)(10)(A)(i)(IV)," before "1902(a)(10)(A)(ii)(IX)".

(f) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section apply (except as provided in this subsection) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1989, with respect to eligibility for medical assistance on or after such date, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(2) PAYMENT ADJUSTMENT.—The amendments made by subsection (b)(2) shall take effect on the date of the enactment of this Act.

(3) DELAY FOR STATE LEGISLATION.—In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating

funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section (other than subsection (b)(2)), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a regular legislative session of 2 years, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 303. PROTECTION OF INCOME AND RESOURCES OF COUPLE FOR MAINTENANCE OF COMMUNITY SPOUSE.

(a) IN GENERAL.—

(1) Title XIX, as amended by the amendment made by section 411(k)(6)(B) of this Act, is amended—

(A) by redesignating section 1924 as section 1925, and

(B) by inserting after section 1923 the following new section:

"TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES

"SEC. 1924. (a) SPECIAL TREATMENT FOR INSTITUTIONALIZED SPOUSES.—

"(1) SUPERSEDES OTHER PROVISIONS.—In determining the eligibility for medical assistance of an institutionalized spouse (as defined in subsection (h)(1)), the provisions of this section supersede any other provision of this title (including sections 1902(a)(17) and 1902(f)) which is inconsistent with them.

"(2) NO COMPARABLE TREATMENT REQUIRED.—Any different treatment provided under this section for institutionalized spouses shall not, by reason of paragraph (10) or (17) of section 1902(a), require such treatment for other individuals.

"(3) DOES NOT AFFECT CERTAIN DETERMINATIONS.—Except as this section specifically provides, this section does not apply to—

"(A) the determination of what constitutes income or resources, or

"(B) the methodology and standards for determining and evaluating income and resources.

"(4) APPLICATION IN CERTAIN STATES AND TERRITORIES.—

"(A) APPLICATION IN STATES OPERATING UNDER DEMONSTRATION PROJECTS.—In the case of any State which is providing medical assistance to its residents under a waiver granted under section 1115, the Secretary shall require the State to meet the requirements of this section in the same manner as the State would be required to meet such requirement if the State had in effect a plan approved under this title.

"(B) NO APPLICATION IN COMMONWEALTHS AND TERRITORIES.—This section shall only apply to a State that is one of the 50 States or the District of Columbia.

"(b) RULES FOR TREATMENT OF INCOME.—

"(1) SEPARATE TREATMENT OF INCOME.—During any month in which an institutionalized spouse is in the institution, except as provided in paragraph (2), no income of the community spouse shall be deemed available to the institutionalized spouse.

"(2) ATTRIBUTION OF INCOME.—In determining the income of an institutionalized spouse or community spouse, after the institutionalized spouse has been determined to be eligible for medical assistance, except as otherwise provided in this section and regardless of any State laws relating to community property or the division of marital property, the following rules apply:

"(A) NON-TRUST PROPERTY.—Subject to subparagraphs (C) and (D), in the case of income not from a trust, unless the instrument providing the income otherwise specifically provides—

"(i) if payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

"(ii) if payment of income is made in the names of the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

"(iii) if payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

"(B) TRUST PROPERTY.—In the case of a trust—

"(i) except as provided in clause (ii), income shall be attributed in accordance with the provisions of this title (including sections 1902(a)(17) and 1902(k)), and

"(ii) income shall be considered available to each spouse as provided in the trust, or, in the absence of a specific provision in the trust—

"(I) if payment of income is made solely to the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

"(II) if payment of income is made to both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each of them; and

"(III) if payment of income is made to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

"(C) PROPERTY WITH NO INSTRUMENT.—In the case of income not from a trust in which there is no instrument establishing ownership, subject to subparagraph (D), one-half of the income shall be considered to be available to the institutionalized spouse and one-half to the community spouse.

"(D) REBUTTING OWNERSHIP.—The rules of subparagraphs (A) and (C) are superseded to the extent that an institutionalized spouse can establish, by a preponderance of the evidence, that the ownership interests in income are other than as provided under such subparagraphs.

"(c) RULES FOR TREATMENT OF RESOURCES.—

"(1) COMPUTATION OF SPOUSAL SHARE AT TIME OF INSTITUTIONALIZATION.—

"(A) TOTAL JOINT RESOURCES.—There shall be computed (as of the beginning of a continuous period of institutionalization of the institutionalized spouse)—

"(i) the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest, and

"(ii) a spousal share which is equal to ½ of such total value.

"(B) ASSESSMENT.—At the request of an institutionalized spouse or community spouse, at the beginning of a continuous period of institutionalization of the institutionalized spouse and upon the receipt of relevant documentation of resources, the State shall promptly assess and document the total value described in subparagraph (A)(i) and shall provide a copy of such assessment and documentation to each spouse and shall retain a copy of the assessment for use under this section. If the request is not part of an application for medical assistance under this title, the State may, at its option as a condition of providing the assessment, require payment of a fee not exceeding the reasonable expenses of providing and documenting the assessment. At the time of providing the copy of the assessment, the State shall include a notice indicating that the spouse has right to a fair hearing under subsection (e)(2)(E) with respect to the determination of the community spouse resource allowance, to provide for an allowance adequate to raise the spouse's income to the minimum monthly maintenance needs allowance.

"(2) ATTRIBUTION OF RESOURCES AT TIME OF INITIAL ELIGIBILITY DETERMINATION.—In determining the resources of an institutionalized spouse at the time of application for benefits under this title, regardless of any State laws relating to community property or the division of marital property—

"(A) except as provided in subparagraph (B), all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse, and

"(B) resources shall not be considered to be available to an institutionalized spouse, to the extent that the amount of such resources does not exceed the amount computed

under subsection (f)(2)(A) (as of the time of application for benefits).

"(3) ASSIGNMENT OF SUPPORT RIGHTS.—The institutionalized spouse shall not be ineligible by reason of resources determined under paragraph (2) to be available for the cost of care where—

"(A) the institutionalized spouse has assigned to the State any rights to support from the community spouse;

"(B) the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but the State has the right to bring a support proceeding against a community spouse without such assignment; or

"(C) the State determines that denial of eligibility would work an undue hardship.

"(4) SEPARATE TREATMENT OF RESOURCES AFTER ELIGIBILITY FOR BENEFITS ESTABLISHED.—During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be eligible for benefits under this title, no resources of the community spouse shall be deemed available to the institutionalized spouse.

"(5) RESOURCES DEFINED.—In this section, the term 'resources' does not include—

"(A) resources excluded under subsection (a) or (d) of section 1613, and

"(B) resources that would be excluded under section 1613(a)(2)(A) but for the limitation on total value described in such section.

"(d) PROTECTING INCOME FOR COMMUNITY SPOUSE.—

"(1) ALLOWANCES TO BE OFFSET FROM INCOME OF INSTITUTIONALIZED SPOUSE.—After an institutionalized spouse is determined to be eligible for medical assistance, in determining the amount of the spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

"(A) A personal needs allowance (described in section 1902(q)(1)), in an amount not less than the amount specified in section 1902(q)(2).

"(B) A community spouse monthly income allowance (as defined in paragraph (2)), but only to the extent income of the institutionalized spouse is made available to (or for the benefit of) the community spouse.

"(C) A family allowance, for each family member, equal to at least ⅓ of the amount by which the amount described in paragraph (3)(A)(i) exceeds the amount of the monthly income of that family member.

"(D) Amounts for incurred expenses for medical or remedial care for the institutionalized spouse (as provided under section 1902(r)).

In subparagraph (C), the term 'family member' only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

"(2) COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE DEFINED.—In this section (except as provided in paragraph (5)), the 'community spouse monthly income allowance' for a community spouse is an amount by which—

"(A) except as provided in subsection (e), the minimum monthly maintenance needs allowance (established under and in accordance with paragraph (3)) for the spouse, exceeds

"(B) the amount of monthly income otherwise available to the community spouse (determined without regard to such an allowance).

"(3) ESTABLISHMENT OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—

"(A) IN GENERAL.—Each State shall establish a minimum monthly maintenance needs allowance for each community spouse which, subject to subparagraph (C), is equal to or exceeds—

"(i) the applicable percent (described in subparagraph (B)) of 1/12 of the nonfarm income official poverty line (defined by the Office of Management and Budget and revised annually in accordance with sections 652 and 673(2) of the Omnibus Budget Reconciliation Act of 1981) for a family unit of 2 members; plus

"(ii) an excess shelter allowance (as defined in paragraph (4)).

A revision of the official poverty line referred to in clause (i) shall apply to medical assistance furnished during and after the second calendar quarter that begins after the date of publication of the revision.

"(B) APPLICABLE PERCENT.—For purposes of subparagraph (A)(i), the 'applicable percent' described in this paragraph, effective as of—

"(i) September 30, 1989, is 122 percent,

"(ii) July 1, 1991, is 133 percent, and

"(iii) July 1, 1992, is 150 percent.

"(C) CAP ON MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—The minimum monthly maintenance needs allowance established under subparagraph (A) may not exceed $1,500 (subject to adjustment under subsections (e) and (g)).

"(4) EXCESS SHELTER ALLOWANCE DEFINED.—In paragraph (3)(A)(ii), the term 'excess shelter allowance' means, for a community spouse, the amount by which the sum of—

"(A) the spouse's expenses for rent or mortgage payment (including principal and interest), taxes and insurance and, in the case of a condominium or cooperative, required maintenance charge, for the community spouse's principal residence, and

"(B) the standard utility allowance (used by the State under section 5(e) of the Food Stamp Act of 1977) or, if the State does not use such an allowance, the spouse's actual utility expenses,

exceeds 30 percent of the amount described in paragraph (3)(A)(i), except that, in the case of a condominium or coopera-

tive, for which a maintenance charge is included under subparagraph (A), any allowance under subparagraph (C) shall be reduced to the extent the maintenance charge includes utility expenses.

"(5) COURT ORDERED SUPPORT.—If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly income so ordered.

"(e) NOTICE AND FAIR HEARING.—

"(1) NOTICE.—Upon—

"(A) a determination of eligibility for medical assistance of an institutionalized spouse, or

"(B) a request by either the institutionalized spouse, or the community spouse, or a representative acting on behalf of either spouse,

each State shall notify both spouses (in the case described in subparagraph (A)) or the spouse making the request (in the case described in subparagraph (B)) of the amount of the community spouse monthly income allowance (described in subsection (d)(1)(B)), of the amount of any family allowances (described in subsection (d)(1)(C)), of the method for computing the amount of the community spouse resources allowance permitted under subsection (f), and of the spouse's right to a fair hearing under this subsection respecting ownership or availability of income or resources, and the determination of the community spouse monthly income or resource allowance.

"(2) FAIR HEARING.—

"(A) IN GENERAL.—If either the institutionalized spouse or the community spouse is dissatisfied with a determination of—

"(i) the community spouse monthly income allowance;

"(ii) the amount of monthly income otherwise available to the community spouse (as applied under subsection (d)(2)(B));

"(iii) the computation of the spousal share of resources under subsection (c)(1);

"(iv) the attribution of resources under subsection (c)(2); or

"(v) the determination of the community spouse resource allowance (as defined in subsection (f)(2));

such spouse is entitled to a fair hearing described in section 1902(a)(3) with respect to such determination. Any such hearing respecting the determination of the community spouse resource allowance shall be held within 30 days of the date of the request for the hearing.

"(B) REVISION OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—If either such spouse establishes that the community spouse needs income, above the level otherwise provided by the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, there shall be substituted, for the minimum monthly maintenance needs allowance in

subsection (d)(2)(A), an amount adequate to provide such additional income as is necessary.

"(C) REVISION OF COMMUNITY SPOUSE RESOURCE ALLOWANCE.—If either such spouse establishes that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under subsection (f)(2), an amount adequate to provide such a minimum monthly maintenance needs allowance.

"(f) PERMITTING TRANSFER OF RESOURCES TO COMMUNITY SPOUSE.—

"(1) IN GENERAL.—An institutionalized spouse may, without regard to section 1917, transfer to the community spouse (or to another for the sole benefit of the community spouse) an amount equal to the community spouse resource allowance (as defined in paragraph (2)), but only to the extent the resources of the institutionalized spouse are transferred to (or for the sole benefit of) the community spouse. The transfer under the preceding sentence shall be made as soon as pacticable after the date of the initial determination of eligibility, taking into account such time as may be necessary to obtain a court order under paragraph (3).

"(2) COMMUNITY SPOUSE RESOURCE ALLOWANCE DEFINED.—In paragraph (1), the 'community spouse resource allowance' for a community spouse is an amount (if any) by which—

"(A) the greatest of—

"(i) $12,000 (subject to adjustment under subsection (g)), or, if greater (but not to exceed the amount specified in clause (ii)(II)) an amount specified under the State plan;

"(ii) the lesser of (I) the spousal share computed under subsection (c)(1), or (II) $60,000 (subject to adjustment under subsection (g));

"(iii) the amount established under subsection (e)(2); or

"(iv) the amount transferred under a court order under paragraph (3),

exceeds

"(B) the amount of the resources otherwise available to the community spouse (determined without regard to such an allowance).

"(3) TRANSFERS UNDER COURT ORDERS.—If a court has entered an order against an institutionalized spouse for the support of the community spouse, section 1917 shall not apply to amounts of resources transferred pursuant to such order for the support of the spouse of a family member (as defined in subsection (d)(1)).

"(g) INDEXING DOLLAR AMOUNTS.—For services furnished during a calendar year after 1989, the dollar amounts specified in subsections (d)(3)(C), (f)(2)(A)(i), and (f)(2)(A)(ii)(II) shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between

September 1988 and the September before the calendar year involved.

"(h) DEFINITIONS.—In this section:

"(1) The term 'institutionalized spouse' means an individual who—

"(A) is in a medical institution or nursing facility or who (at the option of the State) is described in section 1902(a)(10)(A)(ii)(VI), and

"(B) is married to a spouse who is not in a medical institution or nursing facility;

but does not include any such individual who is not likely to meet the requirements of subparagraph (A) for at least 30 consecutive days.

"(2) The term 'community spouse' means the spouse of an institutionalized spouse.".

(2) Section 1919(c)(1)(B)(i) (42 U.S.C. 1396r(c)(1)(B)(i)) is amended by inserting "and of the requirements and procedures for establishing eligibility for medical assistance under this title, including the right to request an assessment under section 1924(c)(1)(B)" before the semicolon.

(b) TAKING INTO ACCOUNT CERTAIN TRANSFERS OF ASSETS.—Subsection (c) of section 1917 (42 U.S.C. 1396p) is amended to read as follows:

"(c)(1) In order to meet the requirements of this subsection (for purposes of section 1902(a)(51)(B)), the State plan must provide for a period of ineligibility in the case of an institutionalized individual (as defined in paragraph (3)) who, at any time during the 30-month period immediately before the individual's application for medical assistance under the State plan, disposed of resources for less than fair market value. The period of ineligibility shall begin with the month in which such resources were transferred and the number of months in such period shall be equal to the lesser of—

"(A) 30 months, or

"(B)(i) the total uncompensated value of the resources so transferred, divided by (ii) the average cost, to a private patient at the time of the application, of nursing facility services in the State or, at State option, in the community in which the individual is institutionalized.

"(2) An individual shall not be ineligible for medical assistance by reason of paragraph (1) to the extent that—

"(A) the resources transferred were a home and title to the home was transferred to—

"(i) the spouse of such individual;

"(ii) a child of such individual who is under age 21, or (with respect to States eligible to participate in the State program established under title XVI) is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614;

"(iii) a sibling of such individual who has an equity interest in such home and who was residing in such individual's home for a period of at least one year immediately before the date of the individual's admission to the medical institution or nursing facility; or

"(iv) a son or daughter of such individual (other than a child described in clause (ii)) who was residing in such individual's home for a period of at least two years immediately before the date of such individual's admission to the medical institution or nursing facility, and who (as determined by the State) provided care to such individual which permitted such individual to reside at home rather than in such an institution or facility;

"(B) the resources were transferred to (or to another for the sole benefit of) the community spouse, as defined in section 1924(h)(2), or the individual's child who is blind or permanently and totally disabled;

"(C) a satisfactory showing is made to the State (in accordance with any regulations promulgated by the Secretary) that (i) the individual intended to dispose of the resources either at fair market value, or for other valuable consideration, or (ii) the resources were transferred exclusively for a purpose other than to qualify for medical assistance; or

"(D) the State determines that denial of eligibility would work an undue hardship.

"(3) In this subsection, the term 'institutionalized individual' means an individual who is an inpatient in a medical institution or nursing facility.

"(4) A State (including a State which has elected treatment under section 1902(f)) may not provide for any period of ineligibility for an individual due to transfer of resources for less than fair market value except in accordance with this subsection.".

(c) NEW SSI POLICY REGARDING DISPOSAL OF RESOURCES FOR LESS THAN FAIR MARKET VALUE.—

(1) ELIMINATION OF SSI PENALTY; NOTIFICATION OF MEDICAID POLICY LIMITING ELIGIBILITY OF INSTITUTIONALIZED INDIVIDUALS FOR BENEFITS BASED ON SUCH DISPOSAL OF RESOURCES.—Subsection (c) of section 1613 (42 U.S.C. 1382b) is amended to read as follows:

"Notification of Medicaid Policy Restricting Eligibility of Institutionalized Individuals for Benefits Based on Disposal of Resources for Less Than Fair Market Value

"(c)(1) At the time an individual (and the individual's eligible spouse, if any) applies for benefits under this title, and at the time the eligibility of an individual (and such spouse, if any) for such benefits is redetermined, the Secretary shall—

"(A) inform such individual of the provisions of section 1917(c) providing for a period of ineligibility for benefits under title XIX for individuals who make certain dispositions of resources for less than fair market value, and inform such individual that information obtained pursuant to subparagraph (B) will be made available to the State agency administering a State plan under title XIX (as provided in paragraph (2)); and

"(B) obtain from such individual information which may be used by the State agency in determining whether or not a period of ineligibility for such benefits would be required by reason of

section 1917(c) if such individual (or such spouse, if any) enters a medical institution or nursing facility.

"(2) The Secretary shall make the information obtained under paragraph (1)(B) available, on request, to any State agency administering a State plan approved under title XIX.".

(2) CONFORMING AMENDMENT.—Subparagraph (B) of section 1611(e)(1) (42 U.S.C. 1382(e)(1)) is amended by adding after and below clause (iii) the following new sentence:

"For purposes of this subsection, a hospital, extended care facility, nursing home, or intermediate care facility which is a 'medical institution or nursing facility' within the meaning of section 1917(c) shall be considered to be receiving payments with respect to an individual under a State plan approved under title XIX during any period of ineligibility of such individual provided for under the State plan pursuant to section 1917(c).".

(d) DISREGARDING PAYMENTS FOR CERTAIN MEDICAL EXPENSES BY INSTITUTIONALIZED INDIVIDUALS.—Section 1902 (42 U.S.C. 1396), as amended by the amendment made by section 411(n)(3) of this Act, is amended by adding at the end the following new subsection:

"(r) For purposes of sections 1902(a)(17) and 1924(d)(1)(D) and for purposes of a waiver under section 1915, with respect to the post-eligibility treatment of income of individuals who are institutionalized or receiving home or community-based services under such a waiver, there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

"(A) medicare and other health insurance premiums, deductibles, or coinsurance, and

"(B) necessary medical or remedial care recognized under State law but not covered under the State plan under this title, subject to reasonable limits the State may establish on the amount of these expenses.".

(e) CONFORMING AMENDMENT.—Section 1902 (42 U.S.C. 1396a), as amended by the amendment made by section 411(n)(3) of this Act, is amended—

(1) in subsection (a)(10)(C)(i)(III), by striking "the same" each place it appears and inserting "no more restrictive than the";

(2) by striking "and" at the end of subsection (a)(49);

(3) by striking the period at the end of the subsection (a)(50) and inserting "; and";

(4) by inserting after paragraph (50) of subsection (a) the following new paragraph:

"(51)(A) meet the requirements of section 1924 (relating to protection of community spouses), and (B) meet the requirement of section 1917(c) (relating to transfer of assets)."; and

(5) in subsection (r), as added by subsection (d)—

(A) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively,

(B) by inserting "(1)" after "(r)", and

(C) by adding at the end the following new paragraph:

"(2)(A) The methodology to be employed in determining income and resource eligibility for individuals under subsection (a)(10)(A)(i)(III), (a)(10)(A)(i)(IV), (a)(10)(A)(ii), (a)(10)(C)(i)(III), or

under subsection (f) may be less restrictive, and shall be no more restrictive, than the methodology—

"(i) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under title XVI, or

"(ii) in the case of other groups, under the State plan most closely categorically related.

"(B) For purposes of this subsection and subsection (a)(10), methodology is considered to be 'no more restrictive' if, using the methodology, additional individuals may be eligible for medical assistance and no individuals who are otherwise eligible are made ineligible for such assistance.".

(f) TREATMENT OF HOMESTEAD EXEMPTION IN MISSOURI.—The State medical assistance plan of Missouri shall not be in compliance with the requirements of title XIX of the Social Security Act as of October 1, 1989, unless such plan is amended to provide that, in determining the resources of any aged, blind, or disabled individual in the State who applies for medical assistance under such plan on or after such date, the State will not consider the home of the individual as a resource, regardless of the value of the home.

(g) EFFECTIVE DATE.—

(1)(A) The amendments made by this section apply (except as provided in this subsection) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after September 30, 1989, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(B) Section 1924 of the Social Security Act (as inserted by subsection (a)) shall only apply to institutionalized individuals who begin continuous periods of institutionalization on or after September 30, 1989, except that subsections (b) and (d) of such section (and so much of subsection (e) of such section as relates to such other subsections) shall apply as of such date to individuals institutionalized on or after such date.

(2)(A) The amendment made by subsection (b) and section 1902(a)(51)(B) of the Social Security Act, apply (except as provided in paragraph (5)) to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1988, or the date of the enactment of this Act, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(B) Section 1917(c) of the Social Security Act, as amended by subsection (b) of this section, shall apply to resources disposed of on or after July 1, 1988.

(C) Notwithstanding subparagraphs (A) and (B), a State may continue to apply the policies contained in the State plan as of June 30, 1988, with respect to resources disposed of before July 1, 1988.

(3) The amendments made by subsection (c) shall apply to transfers occurring on or after July 1, 1988, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

(4) The amendment made by subsection (d) is effective on and after April 8, 1988. The final rule of the Health Care Financing

Administration published on February 8, 1988 (53 Federal Register 3586) is superseded to the extent inconsistent with the amendment made by subsection (d).

(5) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation (other than legislation appropriating funds) in order for the plan to meet the additional requirements imposed by the amendments made by this section (other than subsection (e)), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(6) The amendments made by paragraphs (1) and (5) of subsection (e) shall apply to medical assistance furnished on or after October 1, 1982.

TITLE IV—UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE, OBRA TECHNICAL CORRECTIONS, AND MISCELLANEOUS PROVISIONS

Subtitle A—United States Bipartisan Commission on Comprehensive Health Care

SEC. 401. ESTABLISHMENT.

There is established a commission to be known as the United States Bipartisan Commission on Comprehensive Health Care (in this title referred to as the "Commission").

SEC. 402. DUTIES.

(a) IN GENERAL.—The Commission shall—

(1) examine shortcomings in the current health care delivery and financing mechanisms that limit or prevent access of all individuals in the United States to comprehensive health care, and

(2) make specific recommendations to the Congress respecting Federal programs, policies, and financing needed to assure the availability of—

(A) comprehensive long-term care services for the elderly and disabled,

(B) comprehensive health care services for the elderly and disabled, and

(C) comprehensive health care services for all individuals in the United States.

(b) CONSIDERATIONS IN RECOMMENDATIONS.—In making its recommendations, the Commission shall consider—

(1) the amount and sources (consistent with principles of social insurance) of Federal funds to finance the needed services, including reallocations of existing Federal program funds, and

(2) the most efficient and effective manner of administering such programs.

(c) DEFINITIONS.—In this title:

(1) The term "comprehensive health care services" includes—

(A) inpatient hospital services (including mental health services);

(B) skilled nursing facility services, intermediate care facility services, home health services, and other long-term health care services;

(C) physician services and other outpatient health care services (including mental health services);

(D) periodic general physical examinations, eye examinations, hearing examinations, dental examinations, foot examinations, and other preventive health care services; and

(E) prescription drugs, eyeglasses, hearing aids, orthopedic equipment, and dentures (both complete and partial).

(2) The term "comprehensive long-term care services" includes custodial and noncustodial services in facilities, as well as home and community-based services.

SEC. 403. MEMBERSHIP.

(a) APPOINTMENT.—The Commission shall be composed of 15 members appointed as follows:

(1) The President shall appoint 3 members.

(2) The President Pro Tempore of the Senate shall appoint, after consultation with the minority leader of the Senate, 6 members of the Senate, of whom not more than 4 may be of the same political party.

(3) The Speaker of the House of Representatives shall appoint, after consultation with the minority leader of the House of Representatives, 6 members of the House, of whom not more than 4 may be of the same political party.

(b) CHAIRMAN AND VICE CHAIRMAN.—The Commission shall elect a chairman and vice chairman from among its members.

(c) VACANCIES.—Any vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made and shall not affect the power of the remaining members to execute the duties of the Commission.

(d) QUORUM.—A quorum shall consist of 8 members of the Commission, except that 4 members may conduct a hearing under section 405(a).

(e) MEETINGS.—The Commission shall meet at the call of its chairman or a majority of its members.

(f) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—Members of the Commission are not entitled to receive compensation for service on the Commission. Members may be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Commission.

SEC. 404. STAFF AND CONSULTANTS.

(a) STAFF.—The Commission may appoint and determine the compensation of such staff as may be necessary to carry out the duties of the Commission. Such appointments and compensation may be made without regard to the provisions of title 5, United States Code, that govern appointments in the competitive services, and the provisions of chapter 51 and subchapter III of chapter 53 of such title that relate to classifications and the General Schedule pay rates.

(b) CONSULTANTS.—The Commission may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Commission determines to be necessary to carry out the duties of the Commission.

SEC. 405. POWERS.

(a) HEARINGS AND OTHER ACTIVITIES.—For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties.

(b) STUDIES BY GENERAL ACCOUNTING OFFICE.—Upon the request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

(c) COST ESTIMATES BY CONGRESSIONAL BUDGET OFFICE.—

(1) Upon the request of the Commission, the Director of the Congressional Budget Office shall provide to the Commission such cost estimates as the Commission determines to be necessary to carry out its duties.

(2) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under paragraph (1).

(d) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(e) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties.

(f) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies.

(g) OBTAINING INFORMATION.—The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 5, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

(h) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to

the Commission on a reimbursable basis such administrative support services as the Commission may request.

(i) ACCEPTANCE OF DONATIONS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

SEC. 406. REPORT.

(a) REPORT ON COMPREHENSIVE LONG-TERM CARE SERVICES FOR THE ELDERLY AND DISABLED.—The Commission shall submit to Congress a report, not later than 6 months after the date of the enactment of this Act, containing its findings and recommendations regarding comprehensive long-term care services for the elderly and disabled. The report shall include detailed recommendations for appropriate legislative initiatives respecting such services.

(b) REPORT ON COMPREHENSIVE HEALTH CARE SERVICES.—The Commission shall submit to Congress a report, not later than 1 year after the date of the enactment of this Act, containing its findings and recommendations regarding comprehensive health care services for the elderly and disabled and comprehensive health care services for all individuals in the United States. The report shall include detailed recommendations for appropriate legislative initiatives respecting such services.

SEC. 407. TERMINATION.

The Commission shall terminate 30 days after the date of submission of the report required in section 406(b).

SEC. 408. AUTHORIZATION OF APPROPRIATIONS.

There are authorized to be appropriated $1,500,000 to carry out this title.

Subtitle B—OBRA Technical Corrections

SEC. 411. TECHNICAL CORRECTIONS TO CERTAIN HEALTH CARE PROVISIONS IN THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987.

(a) REFERENCE TO OBRA AND EFFECTIVE DATES.—

(1) REFERENCE.—In this section, the term "OBRA" refers to the Omnibus Budget Reconciliation Act of 1987 (Public Law 100-203).

(2) EFFECTIVE DATE.—Except as specifically provided in this section, the amendments made by this section, as they relate to a provision in OBRA, shall be effective as if they were included in the enactment of that provision in OBRA.

(3) RATIFICATION OF ENROLLMENT CORRECTIONS AND PRINTED ENROLLMENT.—

(A) IN GENERAL.— Except as provided in subparagraph (B), the enrollment corrections noted in footnotes numbered 9 through 72 of OBRA are hereby ratified and shall be considered to have been enacted as part of OBRA. The printed enrollment of title IV of OBRA, as prepared and printed under section 8004 of OBRA (including the footnote corrections described in subparagraph (B) and as incorporating the clarifications described in subparagraph (C)), shall be deemed to constitute title IV of OBRA as enacted.

(B) FOOTNOTE CORRECTIONS.—(i) With respect to the reference to which footnote 28 relates (101 Stat. 1330-81), the reference shall be deemed to have read "1320a–7b)".

(ii) With respect to the word to which footnote 30 relates (101 Stat. 1330-91), the word shall be deemed to have read "the".

(iii) With respect to the designation to which footnote 52 relates (101 Stat. 1330-151), the designation shall be deemed to have read "(F)".

(C) CLARIFICATIONS OF ILLEGIBLE MATTER.—(i) Section 1842(n)(1)(A) of the Social Security Act, as added by section 4051(a) of OBRA (101 Stat. 1330-93), is deemed to have the phrase "the supplier's reasonable charge to individuals enrolled under this part for the test" immediately after "or, if lower, the".

(ii) Section 1834(a)(7)(B)(i) of the Social Security Act, as inserted by section 4062(b) of OBRA (101 Stat. 1330-103), is deemed to have a reference to "1987" immediately after "December".

(b) CORRECTIONS RELATING TO PART 1 OF SUBTITLE A OF TITLE IV (PART A OF THE MEDICARE PROGRAM).—

(1) SECTION 4002.—(A) Subclauses (III) and (IV) of section 1886(b)(3)(B)(i) of the Social Security Act, as amended by section 4002(a) of OBRA, are amended by striking "other hospitals" and inserting "for hospitals located in other urban areas".

(B) Section 1886(b)(3)(B)(i)(IV) of the Social Security Act, as amended by section 4002(a) of OBRA, is amended by striking "percent" each place it appears and inserting "percentage points".

(C) Section 1886(b)(3)(B)(i)(V) of the Social Security Act, as amended by section 4002(a) of OBRA, is amended by inserting "increase" after "market basket percentage".

(D) The second sentence of section 1886(d)(2)(D) of the Social Security Act, as amended by section 4002(b) of OBRA, is amended by striking "the publication described in subsection (e)(5)(B)" and inserting "the publications described in subsection (e)(5)".

(E) Section 4002(c)(1)(B)(iii) of OBRA is amended, in the matter stricken, by striking the comma after "available".

(F) Section 1886(d)(3)(A)(ii) of the Social Security Act, as amended by section 4002(c)(1)(C) of OBRA, is amended by striking "in urban areas" and inserting "in other urban areas".

(G) Section 1886(d)(1)(A)(iii) of the Social Security Act, as amended by section 4002(d) of OBRA, is amended by striking "if greater" and inserting "if the average standardized amount (described in clause (i)(I) or clause (ii)(I) of paragraph (3)(D)) for hospitals within the region of, and in the same rural, large urban, or other urban area as, the hospital is greater than the average standardized amount (described in the respective clause) for hospitals within the United States in that type of area".

(H)(i) Section 1886(d)(2)(D) of the Social Security Act is amended by striking the last sentence (added by section 4002(f)(1)(A) of OBRA).

(ii) Section 4002(f) of OBRA is amended by adding at the end the following new paragraph:

"(3) The second sentence of section 1813(b)(1) of the Social Security Act (42 U.S.C. 1395e(b)(1)) is amended by striking 'applicable percentage increase' and all that follows through 'is applied' and inserting 'Secretary's best estimate of the payment-weighted average of the applicable percentage increases (as defined in section 1886(b)(3)(B)) which are applied'.".

(iii) The amendment made by clause (ii) shall apply to the inpatient hospital deductible for years beginning with 1989.

(I) Section 4002(g) of OBRA is amended—

(i) in paragraph (1)(A), by striking "1886(a)(1)(A)(iii)" and inserting "1886(d)(1)(A)(iii)",

(ii) in paragraphs (1)(B) and (2)(B), by striking "1886(d)(3)(B)" and inserting "1886(b)(3)(B)", and

(iii) in paragraph (6), by striking "1886(d)(10)(B)" and inserting "1886(d)(1)(B)".

(2) SECTION 4003.—Section 4003(d) of OBRA is amended—

(A) in paragraph (2)—

(i) by inserting "(other than under section 1886(d)(5)(F) of such Act)" after "receives payments", and

(ii) by inserting "of such services" after "reasonable costs"; and

(B) in the matter following paragraph (2), by inserting "the" after "facilities of".

(3) SECTION 4004.—Section 4004(a) of OBRA is amended by inserting "(1)" after "SURVEY.—" and by adding at the end the following new paragraph:

"(2) Section 1886(d)(9)(C)(iv) of such Act is amended by adding at the end the following new sentence: 'The second and third sentences of paragraph (3)(E) shall apply to subsection (d) Puerto Rico hospitals under this clause in the same manner as they apply to subsection (d) hospitals under such paragraph and, for purposes of this clause, any reference in such paragraph to a subsection (d) hospital is deemed a reference to a subsection (d) Puerto Rico hospital.'.".

(4) SECTION 4005.—(A) Section 1886(d)(8)(B) of the Social Security Act, as added by section 4005(a)(1)(D) of OBRA, is amended—

(i) by striking "The Secretary" and inserting "For purposes of this subsection, the Secretary", and

(ii) by striking all that follows "if" and inserting the following: "the rural county would otherwise be considered part of an urban area, under the standards for designating Metropolitan Statistical Areas (and for designating New England County Metropolitan Areas) published in the Federal Register on January 3, 1980, if the commuting rates used in determining outlying counties (or, for New England, similar recognized areas) were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or counties of all contiguous Metropolitan Statistical Areas (or New England County Metropolitan Areas).".

(B) Section 1886(d)(8)(C) of the Social Security Act, as added by section 4005(a)(1)(D) of OBRA, is amended by striking "standardized amount" and inserting "standardized amounts".

(C) Section 4005(a) of OBRA is amended—

(i) in paragraph (1)(D), by striking "subparagraph" and inserting "subparagraphs", and

(ii) in paragraph (3), by striking "This section, and the amendments made by paragraph (1)," and inserting "This subsection".

(D) Section 1883(d)(3) of the Social Security Act, as added by section 4005(b)(2)(B) of OBRA, is amended by inserting before the period at the end the following: ", except that such payment shall continue to be made in the period for those patients who are receiving extended care services at the time the hospital reaches the limit specified in this paragraph".

(5) SECTION 4006.—(A) Section 1886(g)(3)(A)(iv) of the Social Security Act, as amended by section 4006(a) of OBRA, is amended by inserting "for payments attributable" after "15 percent".

(B) Section 4006(a) of OBRA is amended—

(i) by adding "and" at the end of subparagraph (A), and

(ii) by redesignating (A) and (B) as paragraphs (1) and (2), respectively.

(6) SECTION 4007.—Section 4007 of OBRA is amended—

(A) in the second sentence of subsection (a), by striking "updata" and inserting "updated";

(B) by amending subsection (b) to read as follows:

"(b) REQUIRING REPORTING OF STANDARDIZED COST REPORT ELECTRONICALLY.—

"(1) IN GENERAL.—Section 1886(f)(1) of the Social Security Act (42 U.S.C. 1395ww(f)(1)) is amended—

"(A) by striking ', for a period ending not earlier than September 30, 1988,',

"(B) by inserting '(A)' after '(f)(1)', and

"(C) by adding at the end the following new subparagraph:

" '(B)(i) Subject to clause (ii), the Secretary shall place into effect a standardized electronic cost reporting format for hospitals under this title.

" '(ii) The Secretary may delay or waive the implementation of such format in particular instances where such implementation would result in financial hardship (in particular with respect to hospitals with a small percentage of inpatients entitled to benefits under this title).'.

"(2) EFFECTIVE DATE.—The amendment made by paragraph (1)(C) shall apply to hospital cost reporting periods beginning on or after October 1, 1989."; and

(C) in subsection (c)—

(i) in paragraph (1)—

(I) by striking "3-year", and

(II) by striking "contracting" and inserting "conducting";

(ii) in paragraph (2), by striking "by category of service and" in subparagraphs (A) and (B);

(iii) in paragraph (2)(C), by striking "(by category of service)";

(iv) in paragraph (2), by striking subparagraph (D) and redesignating subparagraphs (E) through (L) as subparagraphs (D) through (K), respectively;

(v) by amending subparagraph (I), as so redesignated, to read as follows:

"(I) Bad debt and charity care.";

(vi) in paragraph (2), by adding at the end the following:

"The Secretary shall develop a definition of 'outpatient visit' for purposes of reporting hospital information.";

(vii) in paragraph (5), by striking "paragraph (3)" and inserting "paragraph (2)";

(viii) in paragraph (5)(A), by striking "The terms" and all that follows through "as" and inserting "The term 'bad debt and charity care' has such meaning as";

(ix) in paragraph (5)(B)—

(I) by inserting "at least" after "to payors",

(II) by striking "title VIII" and inserting "title XVIII", and

(III) by striking "self-paying individuals" and inserting "and other persons (including self-paying individuals)"; and

(x) in paragraph (6)—

(I) by striking "$1,000,000 for each of" and inserting "a total of $3,000,000 for",

(II) by inserting "or from operation funds" after "research funds",

(III) by striking ", and at least" and all that follows through "operations funds" and inserting "and", and

(IV) by striking "over 3 years".

(7) SECTION 4008.—Section 4008(d)(1)(B) of OBRA is amended by striking "1886" and inserting "1886(d)".

(8) SECTION 4009.—(A) Section 4009(a) of OBRA is amended—

(i) by striking paragraphs (1) and (2) and inserting the following:

"(1) INCREASE IN CIVIL MONETARY PENALTY AND EXCLUSION OF RESPONSIBLE PHYSICIAN VIOLATORS.—Section 1867(d)(2) of the Social Security Act (42 U.S.C. 1395dd(d)(2)) is amended—

"(A) in the second sentence—

"(i) by redesignating such sentence as subparagraph (C),

"(ii) by striking 'previous sentence' and inserting 'this paragraph', and

"(iii) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively; and

"(B) by striking the first sentence and inserting the following: '(A) A participating hospital that knowingly violates a requirement of this section is subject to a civil money penalty of not more than $50,000 for each such violation. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under

this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1128A(a).

" '(B) The responsible physician in a participating hospital with respect to the hospital's violation of a requirement of this subsection is subject to the sanctions described in section 1842(j)(2), except that, for purposes of this subparagraph, the civil money penalty with respect to each violation may not exceed $50,000, rather than $2,000.' "; and

(ii) by redesignating paragraph (3) as paragraph (2).

(B) Section 4009(d)(1)(A) of OBRA is amended, in the matter inserted by such section, by striking the comma after "representatives".

(C) Section 4009(i) of OBRA is amended by striking "New England county metropolitan areas" and "4001(b)" and inserting "urban areas in New England" and "4002(b)", respectively.

(D) Section 4009(j) of OBRA is amended by adding at the end the following new paragraphs:

"(9) Section 1818(c) of the Social Security Act (42 U.S.C. 1395i-2(c)) is amended by striking paragraph (4) and redesignating paragraphs (5) through (7) as paragraphs (4) through (6), respectively.

"(10) Section 9305(d) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking '2 years after the date of the enactment of this Act' and inserting 'January 1, 1990'.".

(c) CORRECTIONS RELATING TO SUBPART A OF PART 2 OF SUBTITLE A OF TITLE IV (HEALTH MAINTENANCE ORGANIZATION REFORMS).—

(1) SECTION 4011.—Subparagraph (F) of section 1876(c)(3) of the Social Security Act, as added by the amendment made by section 4011(a)(1) of OBRA, is amended by moving its indentation 4 ems to the left so its left margin is aligned with the left margin of subparagraph (G) of that section, as added by section 4011(b)(1) of OBRA.

(2) SECTION 4012.—(A)(i) Section 1866(a)(1)(O) of the Social Security Act, as inserted by section 4012(a) of OBRA, is amended by striking "with a risk-sharing contract under section 1876" and inserting "(i) with a risk-sharing contract under section 1876, under section 1876(i)(2)(A) (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967, or under section 222(a) of the Social Security Amendments of 1972, and (ii) which does not have a contract establishing payment amounts for services furnished to members of the organization".

(ii) The amendment made by clause (i) shall apply to admissions occurring on or after the first day of the fourth month beginning after the date of the enactment of this Act.

(B) Section 4012(c) of OBRA is amended by striking "paragraph (2)" and inserting "subsection (a)".

(3) SECTION 4013.—Section 4013 of OBRA is amended by striking "(a) IN GENERAL" and all that follows through the end and inserting the following:

"Section 2350(b)(3) of the Deficit Reduction Act of 1984 is amended by striking 'four years after the date of the enactment of this Act' and inserting 'September 30, 1990'.".

(4) SECTION 4014.—Section 1876(i)(6) of the Social Security Act, as amended by section 4014 of OBRA, is amended—

(A) in subparagraph (A), by inserting ", in addition to any other remedies authorized by law," after "the Secretary may provide", and

(B) in the last sentence of subparagraph (B), by striking "under that section" and inserting "or proceeding under section 1128A(a)".

(5) SECTION 4018.—Section 1876(f)(3)(A) of the Social Security Act, as inserted by section 4018(a) of OBRA, is amended—

(A) by inserting "enrollment and residency requirements under this section and for" after "for purposes of", and

(B) by striking "of the subdivision" and inserting "described in subparagraph (B)(iii) who receive services through the subdivision".

(d) CORRECTIONS RELATING TO SUBPART B OF PART 2 OF SUBTITLE A OF TITLE IV (HOME HEALTH QUALITY).—

(1) SECTION 4021.—(A) Section 1891(a) of the Social Security Act, as added by section 4021(b) of OBRA, is amended—

(i) in paragraph (3)(A), by striking "who is not a licensed health care professional (as defined in subparagraph (F))",

(ii) in paragraph (3)(F), by inserting "physical or occupational therapy assistant," after "occupational therapist,", and

(iii) by striking paragraph (4) and by redesignating paragraphs (5) and (6) as paragraphs (4) and (5), respectively.

(B)(i) Section 1861(n) of the Social Security Act (42 U.S.C. 1395x(n)) is amended by inserting before the period at the end the following: "; except that such term does not include such equipment furnished by a supplier who has used, for the demonstration and use of specific equipment, an individual who has not met such minimum training standards as the Secretary may establish with respect to the demonstration and use of such specific equipment".

(ii) The amendment made by clause (i) shall apply to equipment furnished on or after the effective date provided in section 4021(c) of OBRA.

(2) SECTION 4022.—(A) The third sentence of section 1891(c)(1) of the Social Security Act, as added by section 4022(a) of OBRA, is amended by inserting "(other than subsections (a) and (b))" after "1128A".

(B) Section 1891(d)(2)(A) of the Social Security Act, as added by section 4022(a) of OBRA, is amended by striking "1991" and inserting "1992".

(3) SECTION 4023.—(A) Section 4023 of OBRA is amended by inserting "(a) IN GENERAL.—" before "Section 1891".

(B) Section 1891(f)(2)(A) of the Social Security Act, as added by section 4023 of OBRA, is amended—

(i) by moving the indentation of clauses (i) through (iii) (and the sentence following clause (iii)) 2 ems to the left,

(ii) in clause (i), by striking "for each day of noncompliance" and inserting "in an amount not to exceed $10,000 for each day of noncompliance", and

(iii) by inserting after and below clause (iii), the following:

"The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).".

(C) Section 4023(b) of OBRA is amended by inserting before the period at the end the following: ", and no intermediate sanction described in section 1891(f)(2)(A) of such Act shall be imposed for violations occurring before such effective date".

(4) SECTION 4025.—(A) Section 1864(a) of the Social Security Act is amended—

(i) in the first sentence added by section 4025(a) of OBRA, by striking "most recent accreditation survey conducted with respect to the agency," and inserting "most recent accreditation survey conducted by a State agency or private accreditation agency under section 1865 with respect to the home health agency,", and

(ii) in the second sentence so added—

(I) by inserting "such State or local" before "agency" the first place it appears, and

(II) by striking "section 1864" and inserting "section 1865".

(B) Section 4025 of OBRA is amended—

(i) in subsection (b), by striking "subsection (a)" and inserting "this section" and by redesignating such subsection as subsection (c), and

(ii) by inserting after subsection (a) the following new subsection:

"(b) CONFORMING AMENDMENT.—The last sentence of section 1865(a) of such Act (42 U.S.C. 1395bb(a)) is amended by inserting '(other than a survey with respect to a home health agency' after 'any accreditation survey'.".

(5) SECTION 4026.—(A) Section 1861(v)(1)(L)(iii) of the Social Security Act, as added by section 4026(a)(1) of OBRA, is amended—

(i) by striking "audited" each place it appears and inserting "verified", and

(ii) by adding at the end the following:

"In the case of a home health agency that refuses to provide data, or deliberately provides false data, respecting wages for purposes of this clause upon the request of the Secretary, the Secretary may withhold up to 5 percent of the amount of the payments otherwise payable to the agency under this title until such date as the Secretary determines that such data has been satisfactorily provided.".

(B) Section 4026(a)(2) of OBRA is amended by striking "July 1, 1988" and inserting "July 1, 1989".

(C) Section 4026(b) of OBRA is amended by striking "June 1, 1988" and inserting "June 1, 1989".

(6) SECTION 4027.—Section 4027(a) of OBRA is amended by striking "July 1, 1988" and inserting "April 1, 1989".

(e) CORRECTIONS RELATING TO SUBPART C OF PART 2 OF SUBTITLE A OF TITLE IV (OTHER MEDICARE PART A AND B PROVISIONS).—

(1) SECTION 4032.—(A) Section 4032 of OBRA is amended by striking "AND PHYSICIAN REVIEW" in the heading of subsection (a) and by striking "AND CARRIERS" in the heading of subsection (b).

(B) Section 1816(j)(2) of the Social Security Act, as added by section 4032(a) of OBRA, is amended—

(i) by inserting "in the case of a request for reconsideration of a denial," after "(2)", and

(ii) by inserting "the" before "disposition".

(C) Section 4032(c)(1)(B) of OBRA is amended by striking "claims filed" and inserting "reconsiderations requested".

(2) SECTION 4033.—Section 4033 of OBRA is amended—

(A) by striking "(a) IN GENERAL.—";

(B) by redesignating paragraphs (1) and (2) (and subparagraphs (A) and (B) of paragraph (2)) as subsections (a) and (b) (and paragraphs (1) and (2) of subsection (b)), respectively; and

(C) by aligning the left margins of the matter in such section flush left.

(3) SECTION 4039.—Section 4039 of OBRA is amended by adding at the end the following new subsection:

"(h) TECHNICAL CORRECTIONS.—

"(1) Section 1128A(b) of the Social Security Act (42 U.S.C. 1320a-7a(b)) is amended—

"(A) in paragraph (1)(A), by striking 'XVII' and inserting 'XVIII', and

"(B) in paragraph (2) by inserting 'each' after '$2,000 for'.

"(2) Section 1138(a)(1)(B) of such Act (42 U.S.C. 1320b-8(a)(1)(B)) is amended by striking 'In' and inserting 'in'.

"(3) Section 1154(a)(4) of such Act (42 U.S.C. 1320c-3(a)(4)) is amended—

"(A) by indenting subparagraphs (B) and (C) (and clauses (i) through (iii) of subparagraph (C)) two additional ems;

"(B) in subparagraph (B), by inserting 'risk-sharing' before 'contract under section 1876'; and

"(C) in subparagraph (C)(i), by adding before the comma at the end the following: '(other than the ability to perform review functions under this section that are not described in subparagraph (B))'.

"(4) Section 1154(d) of such Act (42 U.S.C. 1320c-3(d)) is amended by striking '1164(b)(4)' and inserting '1164'.

"(5) Section 1156(b) of such Act (42 U.S.C. 1320c-5(b)) is amended—

"(A) in the second sentence of paragraph (1), by striking 'such services on a reimbursable basis.' and inserting 'services under this Act on a reimbursable basis.', and

"(B) in paragraph (2), by striking 'at such time' and all that follows through 'and shall remain' and inserting 'on the same date and in the same manner as an exclusion from participation under the programs under this Act becomes effective under section 1128(c), and shall remain'.

"(6) Section 1160 of such Act (42 U.S.C. 1320c-9) is amended by adding at the end the following new subsection:

" '(e) For purposes of this section and section 1157, the term "organization with a contract with the Secretary under this part" includes an entity with a contract with the Secretary under section 1154(a)(4)(C).'.

"(7) The heading of section 1870 of such Act (42 U.S.C. 1395gg) is amended to read as follows:

'OVERPAYMENT ON BEHALF OF INDIVIDUALS AND SETTLEMENT OF CLAIMS FOR BENEFITS ON BEHALF OF DECEASED INDIVIDUALS'.

"(8) Section 1876(i)(7) of such Act (42 U.S.C. 1395mm(i)(7)) is amended—

"(A) in subparagraph (A), by striking 'Except as provided under section 1154(a)(4)(C), each' and inserting 'Each';

"(B) in subparagraph (A), by inserting 'or with an entity selected by the Secretary under section 1154(a)(4)(C)' after 'located)'; and

"(C) by striking 'peer' in subparagraph (B) and the second place it appears in subparagraph (A).

"(9) Section 9353 of the Omnibus Budget Reconciliation Act of 1986 is amended—

"(A) in subsection (a)(6)(A)(i), by striking 'paragraphs (1) and (2)(D) shall apply to contracts as of" and inserting 'paragraph (1) shall apply to contracts entered into or renewed on or after';

"(B) in subsection (a)(6)(B), by striking 'amendment made by paragraph (2)(B)' and inserting 'amendments made by paragraphs (2)(B) and (2)(D)'; and

"(C) in subsection (e)(3)(B), by adding at the end the following: 'The provisions of section 1876(i)(7) of the Social Security Act (added by such amendment) shall apply to health maintenance organizations with contracts in effect under section 1876 of such Act (as in effect before the date of the enactment of Public Law 97-248) in the same manner as it applies to eligible organizations with risk-sharing contracts in effect under section 1876 of such Act (as in effect on the date of the enactment of this Act).'.".

(f) CORRECTIONS RELATING TO SUBPART A OF PART 3 OF SUBTITLE A OF TITLE IV (PAYMENTS FOR PHYSICIANS' SERVICES).—

(1) SECTION .4041.—(A) Section 4041(a)(1)(B) of OBRA is amended—

(i) by inserting "as amended retroactively by section 4085(i)(7)(C)," after "(j)(1)(C),", and

(ii) by redesignating the clause added by such section as clause (viii).

(B) The last sentence of section 1842(b)(2) of the Social Security Act, as added by section 4041(a)(3)(A) of OBRA, is amended by striking "and subsection (h)" and inserting ", subsection (h), and section 1845(f)(2)".

(C) Subclause (II) of section 4041(a)(3)(B)(iii) of OBRA is amended to read as follows:

"(II) by striking 'April 1' and inserting 'September 30', and".

(2) SECTION 4042.—(A) Section 1842(b)(4)(F)(iii) of the Social Security Act, as added by section 4042(a) of OBRA, is amended—

(i) in subclause (I), by striking the semicolon and inserting a comma, and

(ii) in subclause (II), by striking "physician's" and inserting "physicians' ".

(B) Section 1842(b)(4)(F)(ii)(I) of the Social Security Act, as added by section 4042(a) of OBRA, is amended by striking "subparagraph (E)(iii)" and inserting "subsection (i)(4)".

(C) Section 4042(b) of OBRA is amended by striking "Section" and all that follows up to "The term" and inserting the following:

"(1) Section 1842 of such Act (42 U.S.C. 1395u) is amended—

"(A) in subsection (h)(7), by striking ', described in paragraph (8)';

"(B) in paragraph (8) of subsection (h)—

"(i) by striking '(8) For purposes of this title, a' and inserting '(1) A',

"(ii) by indenting such paragraph 2 ems, and

"(iii) by inserting before such paragraph the following:

" '(i) For purposes of this title:';

"(C) in subsection (b)(4)(E)—

"(i) by striking '(E) In this section:',

"(ii) by redesignating clauses (i) and (ii), as paragraphs (2) and (3), respectively, and

"(iii) by transferring and inserting such paragraphs, as redesignated, before subsection (j);

"(D) in subsection (b)(4), by redesignating subparagraphs (F) and (G) of subsection (b)(4), as subparagraphs (E) and (F), respectively; and

"(E) by inserting, after the paragraphs transferred and inserted by subparagraph (C)(iii) the following, new paragraph:

" '(4)'.

(D) Section 4042(b) of OBRA is further amended by adding at the end the following:

"(2)(A) Section 1842(b)(4)(A)(vii) of such Act, as redesignated by sections 4041(a)(1)(A)(i) and 4044(a) is amended by striking 'subparagraph (E)(ii)' and inserting 'subsection (i)(3)'.

"(B) Section 1833(l)(2) of such Act (42 U.S.C. 1395l(l)(2)) is amended by striking '1842(b)(4)(E)(ii)' and inserting '1842(i)(3)'.".

(E) The last sentence of section 1842(b)(4)(A)(iv)(II) of the Social Security Act, as added by section 4042(c)(2) of OBRA, is amended by striking "January 1, 1988" and inserting "January 1, 1989".

(F) Section 4042(c) of OBRA is amended—

(i) by striking "Section" and all that follows up to "In the previous sentence" and inserting the following:

"(1) The first sentence of clause (iv) of section 1842(b)(4)(A) of such Act (42 U.S.C. 139u(b)(4)(A)) is amended to read as follows: 'The reasonable charge for physicians' services furnished on or after January 1, 1987, by a nonparticipating physician shall be

no greater than the applicable percent of the prevailing charge levels established under the third and fourth sentences of paragraph (3) (or under any other applicable provision of law affecting the prevailing charge level).'.", and

(ii) by adding at the end the following:

"(2) Subclauses (I) and (II) of section 1842(j)(1)(C)(i) of such Act are amended by striking 'prevailing charge for the year involved for such service furnished by nonparticipating physicians' and inserting 'applicable percent (as defined in subsection (b)(4)(A)(iv)) of the prevailing charge for the year and service involved'.".

(3) SECTION 4044.—(A) Section 4044(a) of OBRA is amended by striking "INCREASE IN PREVAILING CHARGES" and inserting "PREVAILING CHARGE FLOOR".

(B) Section 1842(b)(4)(A)(vi) of the Social Security Act, as inserted by section 4044(a) of OBRA, is amended—

(i) by striking "subparagraph (E)(iii)" and inserting "subsection (i)(4)",

(ii) by striking "the average of the prevailing charge levels" and inserting "the estimated average prevailing charge levels based on the best available data", and

(iii) by striking "for participating physicians".

(4) SECTION 4045.—(A) Section 1842(b)(10) of the Social Security Act, as amended by section 4045(a) of OBRA, is amended—

(i) in subparagraph (A)(i)—

(I) by striking "under paragraph (3)",

(II) by striking "subparagraph (C)" and inserting "subparagraph (B)", and

(III) by striking "for participating and nonparticipating physicians";

(ii) in subparagraph (A)(iii), by striking "clause (i)(II)" and inserting "clause (i)(I)";

(iii) in subparagraph (B) by inserting "(including subsequent insertion of an intraocular lens)" after "cataract surgery"; and

(iv) in subparagraph (D), by inserting "under" after "review".

(B) Section 4045(c)(2) of OBRA is amended—

(i) in subparagraph (B), by inserting before the period at the end the following: "and by striking the second sentence", and

(ii) by adding at the end the following new subparagraph:

"(D) The fourth sentence of section 1842(b)(3) of the Social Security Act (42 U.S.C. 1395u(b)(3)) is amended by inserting '(or under any other provision of law affecting the prevailing charge level)' after 'the level determined under this sentence'.".

(C) Section 1842(j)(1)(D)(iv) of the Social Security Act, as added by section 4045(c)(1)(B) of OBRA, is amended by striking "imposes a charge" and inserting "bills".

(D)(i) Section 1862(a)(15) of the Social Security Act (42 U.S.C. 1395y(a)(15)) is amended by inserting "(including subsequent insertion of an intraocular lens)" after "operation".

(ii) The amendment made by clause (i) shall apply to operations performed on or after 60 days after the date of the enactment of this Act.

(5) SECTION 4046.—(A) Section 1842(b)(11)(C)(i) of the Social Security Act, as inserted by section 4046(a)(1)(C) of OBRA and as designated by section 4063(a)(1)(A), is amended by striking "implantation" and inserting "insertion".

(B) Section 1842(j)(1)(D)(ii)(IV) of the Social Security Act, as inserted by section 4046(a)(2)(A) of OBRA, is amended by striking "is".

*(6) SECTION 4047.—(A) The heading of section 4047 of OBRA is amended by striking "**PRIMARY CARE**" and inserting "**CERTAIN**".*

(B) Section 1842(b)(4)(G) of the Social Security Act, as added by section 4047(a) of OBRA, is amended—

(i) by inserting "than" after "(other", and

(ii) by striking "(as determined under the third and fourth sentences of paragraph (3) and under paragraph (4))".

(C) Section 4047(b) of OBRA is amended by inserting "on or" after "medicare beneficiaries".

(D) The item in the table of contents of title IV of OBRA relating to section 4047 is amended to read as follows:

"Sec. 4047. Customary charges for certain services of new physicians.".

(7) SECTION 4048.—(A) Paragraph (14) of section 1842(b) of the Social Security Act, as added by section 4048(a) of OBRA, is redesignated as paragraph (13).

(B) Section 4048 of OBRA is amended by adding at the end the following new subsection:

"(e) CONFORMING AMENDMENT TO MAXMIMUM ALLOWABLE ACTUAL CHARGE.—Section 1842(j)(1)(C) of the Social Security Act (42 U.S.C. 1395u(j)(1)(C)), as amended by sections 4085(i)(7)(C) and 4041(a)(1)(B) of this title, is amended by adding at the end the following new clause:

" '(ix) If there is a reduction under subsection (b)(13) in the reasonable charge for medical direction furnished by a nonparticipating physician, the maximum allowable actual charge otherwise permitted under this subsection for such services shall be reduced in the same manner and in the same percentage as the reduction in such reasonable charge.'.".

(8) SECTION 4049.—(A) Section 1834(b)(6) of the Social Security Act, as added by section 4049(a)(2) of OBRA, is amended by striking "radiologic" each place it appears and inserting "radiology".

(B) Section 4049(a) of OBRA is amended—

(i) in paragraph (1), by striking "4062(c)(3)" and inserting "4062(d)(3)", and

(ii) in paragraph (2), by striking "4062(a)" and inserting "4062(b)".

(C) Section 1833(a)(1) of the Social Security Act, as amended by section 4049(a)(1) of OBRA, is amended in the clause added by that section by striking "1834(b)(5)" and inserting "1834(b)(6)".

(D) Section 1834(b) of the Social Security Act, as added by section 4049(a)(2) of OBRA, is amended—

(i) in the headings of paragraphs (4)(D) and (5), by inserting "AND SUPPLIERS" after "PHYSICIANS";

(ii) in paragraph (5)(C), by striking "imposes a charge" and inserting "bills";

(iii) in paragraph (5)(C), by inserting "in the same manner as such sanctions may apply to a physician" after "1842(j)(2)";

(iv) in paragraph (6), by striking ", section 1833(a)(1)(I), and section 1842(h)(1)(B)" and inserting "and section 1833(a)(1)(J)"; and

(v) in paragraph (6)(B), by striking "billings" and inserting "the total amount of charges".

(E) Section 4049(b) of OBRA is amended by striking "establish" and inserting "propose".

(9) SECTION 4051.—Section 1842(n) of the Social Security Act, as added by section 4051(a) of OBRA, is amended—

(A) in paragraph (1) in the matter before subparagraph (A)—

(i) by striking "to a patient",

(ii) by inserting "the bill or request for" after "for which",

(iii) by striking "his" and inserting "a", and

(iv) by striking "supervised the test" and inserting "supervised the performance of the test";

(B) in paragraph (1)(A), by striking "to individuals enrolled under this part";

(C) in paragraph (2)(A), by inserting "the payment amount specified in paragraph (1)(A) and" after "other than"; and

(D) in paragraph (3), by striking "or supplier".

(10) FIRST SECTION 4052.—(A) Section 1892(a) of the Social Security Act, as added by the first section 4052(a) of OBRA, is amended—

(i) in paragraphs (2)(C)(ii) and (3)(B), by striking "paragraph (3)" and inserting "paragraph (4)",

(ii) in paragraph (4), by striking "bar" and inserting "exclude", and

(iii) in paragraph (4), by inserting before the period at the end the following: "if a State requests that the physician not be excluded".

(B) The first section 4052(b) of OBRA (relating to conforming reference) is amended by striking "338E(b)(1)" and "254o(b)(1)" and inserting "338E(b)(1)(B)(i)" and "254o(b)(1)(B)(i)", respectively.

(C)(i) Section 1892 of the Social Security Act, as added by the first section 4052(a) of OBRA, is amended—

(I) in the heading, by striking "PHYSICIANS" and "SCHOLARSHIP" and inserting "INDIVIDUALS" and "SCHOLARSHIP AND LOAN", respectively;

(II) by striking "physician" each place it appears (other than the third place it appears in subsection (a)(4)) and inserting "individual";

(III) by striking "physician" the third place it appears in subsection (a)(4) and inserting "practitioner";

(IV) in paragraph (1)(A), by inserting ", the Physician Shortage Area Scholarship Program, or the Health Education Assistance Loan Program," after "Scholarship Program";

(V) in subsection (b), by striking ", and (2)" and all that follows through "Act" and inserting "or under subpart III of part F of title VII of such Act (as in effect before October 1, 1976) and which has not been paid by the deadline established by the Secretary pursuant to such respective section"; and

(VI) in subsection (b), by striking the period at the end and inserting "; or" and by adding at the end the following:

"(2) owed by an individual to the United States by reason of a loan covered by Federal loan insurance under subpart I of part C of title VII of the Public Health Service Act and payment for which has not been cancelled, waived, or suspended by the Secretary under such subpart.".

(ii) Section 733(f) of the Public Health Service Act (42 U.S.C. 294f(f)) is amended by adding at the end the following: "Procedures for reduction of payments under the medicare program are provided under section 1892 of the Social Security Act.".

(iii) The amendments made by this subparagraph shall be effective 30 days after the date of the enactment of this Act.

(11) SECOND SECTION 4052.—(A) The second section 4052(a) of OBRA is amended by striking "is amended" and all that follows through the end and inserting the following: "is amended by inserting before the period at the end of the next-to-last sentence the following: ', and shall remain at such prevailing charge level until the prevailing charge for a year (as adjusted by economic index data) equals or exceeds such prevailing charge level'.".

(B) The second section 4052(b) of OBRA is amended by striking "January" and inserting "April".

(12) SECTION 4054.—(A) Section 4054 of OBRA is amended to read as follows:

"SEC. 4054. APPLYING COPAYMENT AND DEDUCTIBLE TO CERTAIN OUTPATIENT PHYSICIANS' SERVICES.

"(a) IN GENERAL.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended—

"(1) in subsection (a)(1), by striking clause (F),

"(2) in subsection (b), by striking paragraph (3) and by redesignating paragraphs (4) and (5) as paragraphs (3) and (4), respectively, and

"(3) in subsection (i), by striking paragraph (4).

"(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to services furnished on or after April 1, 1988.".

(B) The item relating to section 4054 in the table of contents of title IV of OBRA is amended to read as follows:

"Sec. 4054. Applying copayment and deductible to certain outpatient physicians' services.".

(13) SECTION 4055.—Section 4055 of OBRA is amended—

(A) in subsection (a)(2), by striking "such list" and inserting "such definitions", and

(B) in subsection (b)(1), by striking "dermatology,".

(14) REDESIGNATION.—The second section 4052 of OBRA and sections 4053, 4054, and 4055 of OBRA are redesignated as sections 4053 through 4056, respectively.

(g) CORRECTIONS RELATING TO SUBPART B OF PART 3 OF SUBTITLE A OF TITLE IV (PAYMENTS FOR OTHER PART B SERVICES).—

(1) SECTION 4062.—(A) The heading of section 1834 of the Social Security Act, as inserted by section 4062(b) of OBRA, is amended by inserting "ITEMS AND" after "PARTICULAR".

(B) Subsection (a) of section 1834 of the Social Security Act, as so inserted, is amended—

(i) in paragraph (1)(C), by inserting "or under part A to a home health agency" after "under this part";

(ii) in the second sentence of paragraph (2)(A), by striking "rental" before "payments";

(iii) in paragraph (2)(B)(i), by striking "allowed" and inserting "reasonable", and in paragraphs (3)(B)(i) and (8)(A)(i)(I), by striking "allowable" and inserting "reasonable";

(iv) in paragraph (3)(A), by striking the extra space after "ventilators";

(v) in paragraph (4), by inserting after "individual patient" the following: ", and for that reason cannot be grouped with similar items for purposes of payment under this title,";

(vi) in paragraph (4), by inserting "(A)" after "in a lump-sum amount" and by inserting "(B)" after "for that item, and";

(vii) in paragraph (4), by striking "maintenance and service" each place it appears and inserting "maintenance and servicing", in paragraph (7)(A)(iii), by striking "service and maintenance" and inserting "maintenance and servicing", and in paragraphs (7)(A)(ii) and (11)(A), by striking "servicing" and inserting "maintenance and servicing";

(viii) in paragraph (7)(A)(iii)(I), by striking "fee established by the carrier" and inserting "fee or fees established by the Secretary ";

(ix) in paragraph (9)(A)(ii)(I), by striking "12-month period" and inserting "6-month period";

(x) in paragraph (9)(A)(ii)(II), by striking "and to 1991" and inserting ", 1991, and 1992";

(xi) in paragraphs (9)(B)(i) and (10)(B)(i), by striking the comma after "1991";

(xii) in paragraph (9)(C)(i), by striking "subparagraph (A)(ii)(I)" and inserting "subparagraph (A)(ii)";

(xiii) in paragraph (10)(B), by inserting before the period the following: "and payments under this subsection as such provisions apply to physicians' services and physicians and a reasonable charge under section 1842(b)";

(xiv) in the last sentence of paragraph (11)(A), by striking "under subsection (j)(2)" and inserting "under section 1842(j)(2)";

(xv) in paragraph (12), by striking "(as defined in section 1886(d)(2)(D))"; and

(xvi) by striking paragraph (14).

(C) Section 4062(c)(4) of OBRA is amended—

(i) by inserting "and payment of a reasonable copying fee which the Secretary may establish" after "upon written request", and

(ii) by inserting before the period at the end the following: ", but only in a form which does not permit identification of individual suppliers".

(D) The last sentence of section 1866(a)(2)(A) of the Social Security Act, as added by section 4062(d)(4) of OBRA, is amended by striking "section 1834(a)(2)" and inserting "section 1834(a)(1)(B)".

(E) The matter added by section 4062(d)(3)(A)(ii) of OBRA is amended by striking "and" before "(I)".

(2) SECTION 4063.—(A) Section 1842(b)(11)(C)(ii) of the Social Security Act, as amended by section 4063(a)(1)(A) of OBRA, is amended—

(i) by striking "implanted" and inserting "inserted", and

(ii) by inserting "or subsequent to" after "during".

(B) Subclause (IV) of section 1842(j)(1)(D)(ii) of the Social Security Act, as inserted by section 4063(a)(2)(A) of OBRA, is redesignated as subclause (V) and is amended by striking "is".

(C) Section 4063(a)(2)(B) of OBRA is amended by striking clause (ii) and by redesignating clauses (iii) and (iv) as clauses (ii) and (iii), respectively.

(D) Section 1833(i)(2)(A)(iii) of the Social Security Act, as inserted by section 4063(b)(3) of OBRA, is amended—

(i) by striking "implantation" and inserting "insertion", and

(ii) by inserting "or subsequent to" after "during".

(E) Section 4063 of OBRA is amended by adding at the end the following new subsection:

"(e) PREVENTION OF ADDITIONAL BILLINGS FOR IOLS.—

"(1) Section 1833(i) of the Social Security Act (42 U.S.C. 1395l(i)) is amended by adding at the end the following new paragraph:

" '(6) Any person, other than a facility having an agreement under section 1832(a)(2)(F)(i), who knowingly and willfully presents, or causes to be presented, a bill or request for payment, for an intraocular lens inserted during or subsequent to cataract surgery for which payment may be made under paragraph (2)(A)(iii), is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).'.

"(2) Section 1832(a)(2)(F)(i) of such Act (42 U.S.C. 1395k(a)(2)(F)(i)) is amended by inserting '(including intraocular lens in cases described in section 1833(i)(2)(A)(iii))' after 'services' each place it appears.".

(3) SECTION 4064.—(A) Section 4064(a) of OBRA is amended by striking all that follows the first dash and inserting the follow-

ing: "Paragraph (2) of section 1833(h) of the Social Security Act (42 U.S.C. 1395l(h)) is amended—

"(1) by inserting '(A)(i)' after '(2)';

"(2) in the second sentence—

"(A) by redesignating clauses (A) and (B) as clauses (i) and (ii), respectively, and

"(B) by designating such sentence as subparagraph (B); and

"(3) by adding at the end of subparagraph (A)(i), as designated under paragraph (1), the following new clause:

"(ii) Notwithstanding any other provision of this subsection—

"(I) any change in the fee schedules which would have become effective under this subsection for tests furnished on or after January 1, 1988, shall not be effective for tests furnished during the 3-month period beginning on January 1, 1988, and

"(II) the Secretary shall not adjust the fee schedules under clause (i) to take into account any increase in the consumer price index for 1988.".

(B) Section 4064(b)(1) of OBRA is amended—

(i) by striking "1833(h)(2) of the Social Security Act (42 U.S.C. 1395l(h)(2))" and inserting "1833(h)(2)(A) of the Social Security Act (42 U.S.C. 1395l(h)(2)(A)), as amended by subsection (a),";

(ii) by striking "the following: 'In establishing fee schedules under the first sentence of this paragraph with respect to" and inserting "the following new clause:

" '(iii) In establishing fee schedules under clause (i) with respect to"; and

(iii) by moving the indentation of all the matter added following "with respect to" 2 ems to the left.

(C) The clause added by section 4064(b)(1) of OBRA, as amended by subparagraph (A), is amended by inserting before the period at the end the following: ", and such reduced fee schedules shall serve as the base for 1989 and subsequent years".

(D) Section 1833(h)(4)(B)(ii) of the Social Security Act, as amended by section 4064(b)(2)(B) of OBRA, is amended by inserting "after" before "March".

(E) Section 4064(c) of OBRA is amended by striking all that follows the dash and inserting the following: "Section 1833(h)(1)(D) of such Act is amended by inserting ', in a sole community hospital (as defined in the last sentence of section 1886(d)(5)(C)(ii)),' after 'a hospital laboratory'.".

(F) Section 4064(c) of OBRA is amended by inserting "(1)" after the dash and by adding at the end the following new paragraph:

"(2) The amendment made by paragraph (1) shall apply with respect to diagnostic laboratory tests furnished on or after April 1, 1988.".

(G) Section 1846 of the Social Security Act, as added by section 4064(d)(1) of OBRA, is amended—

(i) in subsection (a)—

(I) by striking "certified" and "certification" and inserting "approved" and "approval", respectively,

(II) by inserting "or for coverage" after "conditions of participation", and

(III) by striking "cancelling immediately the certification of the provider or clinical laboratory" and inserting "terminating immediately the provider agreement or cancelling immediately approval of the clinical laboratory";

(ii) in subsections (b)(1)(A) and (b)(2)(A)(iv), by striking "certified";

(iii) in subsection (b)(2)(A)(ii), by striking "civil fines and penalties" and inserting "civil money penalties in an amount not to exceed $10,000 for each day of substantial noncompliance";

(iv) in subsection (b)(2)(A), by adding at the end the following new sentence:

"The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (ii) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).";

(v) in subsection (b)(2)(A)(iii), by striking "certification";

(vi) in subsection (b)(2)(A)(iv), by striking "provided on or after the date in" and inserting "furnished on or after the date on"; and

(vii) in subsection (b)(3), by striking "fines" and inserting "penalties" each place it appears.

(H) The matter inserted in section 1861(s) of the Social Security Act by section 4064(e)(1) of OBRA is amended by inserting a comma after "year".

*(4) SECTION 4066.—(A) The heading of section 4066 of OBRA is amended by inserting "**AND OTHER DIAGNOSTIC TESTS**" after "**RADIOLOGY**".*

(B) The item relating to section 4066 in the table of contents of title IV of OBRA is amended to read as follows:

"Sec. 4066. Payments to hospital outpatient departments for radiology and other diagnostic tests.".

(C) Section 1833(n) of the Social Security Act, as added by section 4066(a)(2) of OBRA, is amended—

(i) in paragraph (1)(A), by striking "beginning on or after October 1, 1988, under this part for services described in subsection (a)(2)(E)" and inserting "for services described in subsection (a)(2)(E)(i) furnished under this part on or after October 1, 1988, and for services described in subsection (a)(2)(E)(ii) furnished under this part on or after October 1, 1989,";

(ii) in paragraph (1)(B)(i)(II), by inserting "or (for services described in subsection (a)(2)(E)(i) furnished on or after January 1, 1989) the fee schedule amount established" after "the prevailing charge"; and

(iii) by amending subclauses (I) and (II) of paragraph (1)(B)(ii) to read as follows:

"(I) The term 'cost proportion' means 50 percent, except that such term means 65 percent in the case of outpatient radiology services for portions of cost reporting periods which occur in

fiscal year 1989 and in the case of diagnostic procedures described in subsection (a)(2)(E)(ii) for portions of cost reporting periods which occur in fiscal year 1990.

"(II) The term 'charge proportion' means 100 percent minus the cost proportion.".

(5) SECTION 4067.—Section 1833(f) of the Social Security Act, as inserted by section 4067(a) of OBRA, is amended by striking "medicare economic index (referred to in the fourth sentence of section 1842(b)(3)) applicable to physicians' services" and inserting "MEI (as defined in section 1842(i)(3)) applicable to primary care services (as defined in section 1842(i)(4))".

(6) SECTION 4068.—The last sentence of section 1135(d)(3) of the Social Security Act, as added by section 4068(b)(1) of OBRA, is amended by striking "speciality" and inserting "specialty".

(h) CORRECTIONS RELATING TO SUBPART B OF PART 3 OF SUBTITLE A OF TITLE IV (PART B ELIGIBILITY AND BENEFITS CHANGES).—

(1) SECTION 4070.—(A) The last sentence of section 1833(c) of the Social Security Act, as added by section 4070(a)(2) of OBRA, is amended by striking "prescribing or monitoring prescription drugs" and inserting "monitoring or changing drug prescriptions".

(B) Section 1861(ff) of the Social Security Act, as added by section 4070(b)(2) of OBRA, is amended—

(i) by inserting before such subsection the following heading:

"Partial Hospitalization Services", and

(ii) in paragraph (3), by striking "hospital-based or hospital-affiliated (as defined by the Secretary)" and inserting "furnished by a hospital to its outpatients".

(2) SECTION 4071.—Section 1861(s)(10)(A) of the Social Security Act, as amended by section 4071(a) of OBRA, is amended by inserting ", subject to section 4071(b) of the Omnibus Budget Reconciliation Act of 1987," before "influenza vaccine".

(3) SECTION 4072.—(A) Section 1861(s)(12) of the Social Security Act, as amended by section 4072(a) of OBRA, is amended by inserting "subject to section 4072(e) of the Omnibus Budget Reconciliation Act of 1987," after "(12)".

(B) Section 4072(b) of OBRA is amended—

(i) by striking "by inserting after subsection (e)" and inserting "by adding at the end, as previously amended,", and

(ii) by redesignating the subsection added by such section as subsection (o).

(4) SECTION 4073.—Section 4073 of OBRA is amended—

(A) by striking paragraph (1) of subsection (b);

(B) in paragraph (2) of subsection (b)—

(i) by redesignating such paragraph as paragraph (1);

(ii) by inserting "and" at the end of subparagraph (A);

(iii) by striking subparagraph (B);

(iv) in the matter added by subparagraph (C)—

(I) by striking "and (I)" and inserting "(K)",

(II) by inserting "80 percent of the lesser of the actual charge for the services or" after "amounts paid shall be",

(III) by striking "but in no event more than" and inserting "but in no event shall such fee schedule exceed", and

(IV) by striking the semicolon and inserting a comma; and

(v) by redesignating subparagraph (C) as subparagraph (B);

(C) in paragraph (3) of subsection (b)—

(i) by inserting ", as previously amended," after "at the end",

(ii) by redesignating such paragraph as paragraph (2),

(iii) by redesignating the subsection added by such paragraph as subsection (p), and

(iv) by adding at the end of the subsection added by such paragraph the following: "Except for deductible and coinsurance amounts applicable under section 1833, whoever knowingly and willfully presents, or causes to be presented, to an individual enrolled under this part a bill or request for payment for services described in the previous sentence, is subject to a civil money penalty of not to exceed $2,000 for each such bill or request. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).";

(D) in the subsection added by subsection (c)—

(i) by redesignating such subsection as subsection (gg), and

(ii) in paragraph (1), by striking "his" and inserting "the nurse-midwife's" and by striking "physician's" and inserting "physicians' "; and

(E) in the matter inserted by subsection (d)(1), by striking "section 1861(ff)" and inserting "section 1861(gg)".

(5) SECTION 4074.—Section 4074 of OBRA is amended—

(A) in the matter inserted by subsection (a)(1), by striking "(ff)" and inserting "(hh)", and

(B) by redesignating the subsection added by subsection (b) as subsection (hh).

(6) SECTION 4076.—Subsection (a) of section 4076 of OBRA is amended to read as follows:

"(a) SERVICES COVERED.—Section 1861(s)(2)(K) of the Social Security Act (42 U.S.C. 1395x(s)(2)(K)) is amended by inserting '(I)' before 'in a hospital' and by striking 'or as an assistant at surgery' and inserting ', (II) as an assistant at surgery, or (III) in a rural area (as defined in section 1886(d)(2)(D)) that is designated, under section 332(a)(1)(A) of the Public Health Service Act, as a health manpower shortage area,'.".

(7) SECTION 4077.—Section 4077(b) of OBRA is amended—

(A) in paragraph (1), by inserting "by section 4073(a) of this title" after "as amended";

(B) by striking paragraph (2);

(C) in paragraph (3)—

(i) by striking "1395k(a)(1))" and inserting "1395l(a)(1)),

(ii) by striking subparagraphs (A) and (B),

(iii) in subparagraph (C), by striking "(I)" and inserting "(K)" and by redesignating such subparagraph as subparagraph (A),

(iv) in subparagraph (D), by striking "subparagraph:" and inserting "clause:" and by redesignating such subparagraph as subparagraph (B), and

(v) in the matter added by subparagraph (B), as so redesignated—

(I) by striking "(J)" and inserting "(L)", and

(II) by inserting "80 percent of the lesser of the actual charge for the services or" after "amounts paid shall be";

(D) in paragraph (4), by striking "section 4073(b)(3)" and inserting "4073(b)(2)";

(E) in paragraph (5), by redesignating the subsection (gg) added by such paragraph as subsection (ii); and

(F) by redesignating paragraphs (3) through (6) as paragraphs (2) through (5), respectively.

(8) SECTION 4079.—Section 4079(c)(1) of OBRA is amended by striking "subsection (d)" and inserting "subsection (e)".

(i) PROVISIONS RELATING TO SUBPART D OF PART 3 OF SUBTITLE A OF TITLE IV (OTHER PART B PROVISIONS).—

(1) SECTION 4081.—(A) Section 1842(h)(3)(B) of the Social Security Act, as added by section 4081(a) of OBRA, is amended—

(i) in the second sentence—

(I) by striking "claims" and inserting "payment", and

(II) by striking "including such information as the Secretary determines is generally provided" and inserting "shall include an explanation of benefits and any additional information that the Secretary may determine to be appropriate in order";

(ii) in the third sentence, by striking "arrangements" and inserting "agreements"; and

(iii) in the fourth sentence—

(I) by inserting "by a carrier" after "under this subparagraph", and

(II) by inserting before the period at the end the following: ", and such user fees shall be collected and retained by the carrier".

(B) Section 4081(b)(2) of OBRA is amended by redesignating subparagraphs (A) through (C) as subparagraphs (B) through (D), respectively, and by inserting before subparagraph (B), as so redesignated, the following:

"(A) in the matter before paragraph (1), by inserting '(or, with respect to paragraph (3), the issuer of the policy)' after 'he finds that such policy',".

(C) Section 1882(c)(3) of the Social Security Act, as inserted by section 4081(b)(2)(C) of OBRA, is amended—

(i) in subparagraph (A), by striking "claims form" each place it appears and inserting "claim form" in the first 2 places and "notice" in the third place,

(ii) in subparagraph (B)(i), by inserting "under the policy" after "payment determination", and

(iii) in subparagraph (B)(ii), by striking "appropriate payment" and inserting "payment covered by such policy".

(D) Section 4081(c)(2)(B)(i) of OBRA is amended by striking "medical" and inserting "medicare".

(E) Section 4081(c)(2)(B)(ii) of OBRA is amended by inserting "or which has not enacted such legislation before July 1, 1988," after "in which such legislation may be considered".

(2) SECTION 4082.—Section 4082(c) of OBRA is amended—

(A) by striking "1842(b)(5) of such Act (42 U.S.C. 1395u(b)(5)" and inserting "1842(b)(2) of such Act (42 U.S.C. 1395u(b)(2))", and

(B) in paragraph (1), by striking "(5)" and inserting "(2)".

(3) SECTION 4084.—Section 4084 of OBRA is amended by adding at the end the following new subsection:

"(c) ADDITIONAL TECHNICAL CORRECTIONS.—

"(1) Section 1861(bb)(2) of the Social Security Act (42 U.S.C. 1395x(bb)(2)) is amended by adding at the end the following: 'Such term also includes, as prescribed by the Secretary, an anesthesiologist assistant.'.

"(2) Section 1833(a)(1)(H) of such Act (42 U.S.C. 1395l(a)(1)(H)) is amended by striking 'lesser of the actual charge' and inserting 'least of the actual charge, the prevailing charge that would be recognized if the services had been performed by an anesthesiologist,'.

"(3) The amendments made by this subsection shall apply to services furnished after December 31, 1988.".

(4) SECTION 4085.—(A) Section 1845(f) of the Social Security Act, as added by section 4085(a) of OBRA, is amended—

(i) in paragraph (1), by striking "October 1st" and inserting "December 31st", and

(ii) in paragraph (2), by striking "July 1st of the following year" and inserting "the later of (A) July 1st of the following year, or (B) 45 days after the date of a reasonable charge update".

(B) Subparagraph (D) of section 1833(h)(5) of the Social Security Act, as added by section 4085(b)(1) of OBRA, is amended—

(i) by striking "If a person" and all that follows through "under subparagraph (C)" and inserting the following: "A person may not bill for a clinical diagnostic laboratory test performed by a laboratory, other than a rural health clinic, other than on an assignment-related basis. If a person knowingly and willfully and on a repeated basis bills for a clinical diagnostic laboratory test in violation of the previous sentence", and

(ii) by striking "section 1842(j)(2)" and inserting "paragraphs (2) and (3) of section 1842(j) in the same manner such paragraphs apply with respect to a physician".

(C) Section 4085(i) of OBRA is amended—

(i) in the matter inserted by paragraph (1)(A), by inserting a comma after "assignment-related basis";

(ii) in paragraph (1), by striking subparagraph (B);

(iii) in paragraph (11), by striking "9367(a)" and inserting "4072(a)";

(iv) in paragraph (21)(D)(i), by inserting "by" after "(i)";

(v) in paragraph (21)(D)(ii), by striking "and by" and all that follows up to the semicolon; and

(vi) by adding at the end the following:

"(22)(A) Section 1832(a)(2)(F)(ii) of the Social Security Act (42 U.S.C. 1395k(a)(2)(F)(ii)) is amended by striking 'an assignment described in section 1842(b)(3)(B)(ii)' and inserting 'payment on an assignment-related basis'.

"(B) Section 1833(h)(5) of such Act (42 U.S.C. 1395l(h)(5)) is amended, in each of subparagraphs (A) and (C), by striking 'on the basis of an assignment' and all that follows through '1870(f)(1),' and inserting 'on an assignment-related basis'.

"(C) Section 1842(b)(7)(B)(iii) of such Act (42 U.S.C. 1395u(b)(7)(B)(ii)) is amended by striking 'the basis of' and all that follows through '1870(f)(1)' and inserting 'an assignment-related basis'.

"(23) Section 1833(l)(5)(B)(ii) of such Act (42 U.S.C. 1395k(l)(5)(B)(ii)) is amended—

"(A) in the first sentence by striking 'monetary' and inserting 'money', and

"(B) by amending the second sentence to read as follows: 'The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).'.

"(24) The fourth sentence of section 1842(b)(3) of such Act (42 U.S.C. 1395u(b)(3)) is amended by striking 'physician services' and 'physicians services' and inserting 'physicians' services' in both places.

"(25) Section 1842(b)(12)(C) of such Act (42 U.S.C. 1395u(b)(12)(C)) is amended—

"(A) in the first sentence by striking 'monetary' and inserting 'money', and

"(B) by amending the second sentence to read as follows: 'The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).'.".

"(26) Section 1842(j)(2) of such Act (42 U.S.C. 1395u(j)(2)(B)) is amended—

"(A) by striking 'title' each place it appears and inserting 'Act', and

"(B) in subparagraph (B)—

"(i) by striking 'the imposition of',

"(ii) by inserting 'and assessments' after 'such penalties', and

"(iii) by amending the second sentence to read as follows: 'The provisions of section 1128A (other than the

first 2 sentences of subsection (a) and other than subsection (b)) shall apply to a civil money penalty and assessment under subparagraph (B) in the same manner as such provisions apply to a penalty, assessment, or proceeding under section 1128A(a), except to the extent such provisions are inconsistent with subparagraph (A) or paragraph (3).'.".

"(27) Section 1842(l)(1)(C)(i) of such Act (42 U.S.C. 1395u(l)(1)(C)(i)) is amended by inserting 'the physician establishes that' after '(i)'.

"(28) Section 1866(g) of such Act (42 U.S.C. 1395cc(g)) is amended—

"(A) in the first sentence by striking 'monetary' and inserting 'money', and

"(B) by amending the second sentence to read as follows: 'The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).'.".

(D)(i) Section 1862(e) of the Social Security Act (42 U.S.C. 1395y(e)) is amended—

(I) by striking "or section 1128A" and inserting ", 1128A, 1156, 1842(j)(2), or 1867(d)",

(II) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), and

(III) by inserting "(1)" after "(e)".

(ii) Section 1890 of the Social Security Act, as added by section 10 of Public Law 100-93, is amended—

(I) by striking its heading;

(II) by striking "SEC. 1890" and inserting "(2)";

(III) by inserting "1842(j)(2)," before "1862(d),";

(IV) by striking "or 1866" and inserting "1866, or 1867(d)"; and

(V) by transferring and adding such provision at the end of section 1862(e) of such Act.

(j) CORRECTIONS TO PART 4 OF SUBTITLE A OF TITLE IV (RELATING TO PEER REVIEW ORGANIZATIONS).—

(1) SECTION 4091.—Section 4091(a)(1)(B) of OBRA is amended by striking "renewals occurring" and inserting "contracts expiring".

(2) SECTION 4093.—Section 1154(a)(3) of the Social Security Act, as amended by section 4093(a) of OBRA, is amended by amending the last sentence to read as follows:

"(C) The discussion and review conducted under subparagraph (B)(ii) shall not affect the rights of a practitioner or provider to a formal reconsideration of a determination under this part (as provided under section 1155).".

(3) SECTION 4094.—(A) Section 4094(a) of OBRA is amended by striking "subparagraph (B)" and inserting "subparagraph (A)".

(B) Section 1154(a)(15) of the Social Security Act, as added by section 4094(b) of OBRA, is amended by striking "at at" and inserting "in at".

(4) SECTION 4096.—(A) Section 4096(a)(1)(A) of OBRA is amended by striking "(b)(3)(ii)" and inserting "(b)(3)(B)(ii)".

(B) Section 1870(f) of the Social Security Act, as amended by section 4096(a)(2) of OBRA, is amended by striking "specified in subclauses (I) and (II) of" and inserting "of assignment specified in".

(C) Sections 1154(e)(3)(A)(i) and 1154(e)(3)(B) (42 U.S.C. 1320c-3(e)(3)(A)(i), 1320c-3(e)(2)(B)), as amended by section 4096(c) of OBRA, are each amended by striking "or (2)" before "paragraph (2)".

(5) SECTION 4097.—Section 4097(b) of OBRA is amended by striking "1866(a)(4)(C)(ii) of such Act (42 U.S.C. 1395cc(a)(4)(C)(ii))" and inserting "1866(a)(3)(C)(ii) of such Act (42 U.S.C. 1395cc(a)(3)(C)(ii))".

(k) CORRECTIONS TO SUBTITLE B OF TITLE IV (RELATING TO MEDICAID).—

(1) TABLE OF CONTENTS.—The table of contents of title IV of OBRA is amended by striking the item relating to section 4105 and by redesignating the items relating to sections 4106 and 4107 as relating to sections 4105 and 4106, respectively.

(2) SECTION 4101.—Section 1916(c)(1) of the Social Security Act, as inserted by section 4101(d)(1)(C) of OBRA, is amended by striking "nonfarm".

(3) SECTION 4102.—(A) Section 1915(d)(5)(B) of the Social Security Act, as amended by section 4102(a)(1)(B) of OBRA, is amended—

(i) in clause (iii)(III), by striking "75" and inserting "65", and

(ii) by inserting before "Effective on" the following: "The Secretary shall develop (by not later than October 1, 1989) a method for projecting, on a State-specific basis, the percentage increase in the number of residents in each State who are over 75 years of age for any period.".

(B) Section 1915(d)(5)(C)(i) of the Social Security Act, as amended by section 4102(a)(1)(B) of OBRA, is amended—

(i) by striking "(4)(B)," and inserting "(4), and", and

(ii) by striking ", and services furnished" and all that follows through "subsection (c)".

(4) SECTION 4103.—Section 1905(a)(5)(B) of the Social Security Act, as inserted by section 4103(a) of OBRA, is amended by striking "subparagraph" and inserting "clause".

(5) SECTION 4104.—(A) Paragraph (1) of section 4104(1) of OBRA is amended to read as follows:

"(1) by striking ', or' at the end of subclause (IX) and inserting a semicolon and by inserting 'or' at the end of subclause (X); and".

(B) Section 1902(a)(10)(A)(ii)(XI) of the Social Security Act, as added by section 4104(2) of OBRA, is amended—

(i) by striking "are more restrictive" and inserting "may be more restrictive", and

(ii) by striking the period at the end and inserting a semicolon.

(6) SECTION 4112.—(A) Section 4112 of OBRA is amended—

(i) in subsection (a)(2)(A)—

(I) by striking "such date" and inserting "April 1, 1989", and

(II) by inserting ", effective for inpatient hospital services provided on or after July 1, 1989" before the period;

(ii) in subsection (a)(2)(B)—

(I) by striking "such date" and inserting "April 1, 1990", and

(II) by inserting ", effective for inpatient hospital services provided on or after July 1, 1990" before the period;

(iii) the undesignated paragraph at the end of subsection (a) is amended—

(I) by striking "June 30 of each year in which the State is required to submit" and inserting "90 days after the date a State submits",

(II) by indenting all of such paragraph 2 ems, and

(III) by designating the first two sentences thereof as paragraph (3) and the last sentence thereof as paragraph (4);

(iv) in subsection (b)(2), by striking "the State plan" and inserting "a State plan";

(v) in subsection (b)(3)(B)(i), by inserting ", less the portion of any cash subsidies described in clause (i)(II) in the period reasonably attributable to inpatient hospital services" after "charity care in a period";

(vi) in subsection (c)—

(I) by striking "paragraphs (2)(A) and (2)(B)" and inserting "paragraphs (1)(B) and (2)(A) of subsection (a)",

(II) by striking "paragraph (2)(A)" and "paragraph (2)(B)" and inserting "such paragraph (1)(B)" and "such paragraph (2)(A)", respectively,

(III) in paragraph (1), by inserting "at least" after "equal to",

(IV) in paragraph (2), by inserting "(without regard to the election made by a State under subsection (b)(1))" after "payment) and",

(V) in the matter after paragraph (2), by inserting "at least" before "one-third" and before "two-thirds", and

(VI) by adding at the end the following new sentences: "In the case of a hospital described in subsection (d)(2)(A)(i) (relating to children's hospitals), in computing the hospital's disproportionate share adjustment percentage for purposes of paragraph (1)(B) of this subsection, the disproportionate patient percentage (defined in section 1886(d)(5)(F)(vi)) shall be computed by substituting for the fraction described in subclause (I) of such section the fraction described in subclause (II) of that section. If a State elects in a State plan amendment under subsection (a) to provide the payment adjustment described in paragraph (2), the State must include in the amendment a detailed description of the specific methodology to be used in determining the specified additional payment amount (or increased per-

centage payment) to be made to each hospital qualifying for such a payment adjustment and must publish at least annually the name of each hospital qualifying for such a payment adjustment and the amount of such payment adjustment made for each such hospital.''; and

(vii) in subsection (e)—

(I) by inserting ''(1)'' after ''SPECIAL RULE.—'',

(II) by inserting ''based on a pooling arrangement involving a majority of the hospitals participating under the plan'' after ''payment adjustments'', and

(III) by adding at the end the following new paragraph:

''(2) In the case of a State that used a health insuring organization before January 1, 1986, to administer a portion of its plan on a State-wide basis, during the 3-year period beginning on July 1, 1988—

''(A) the requirements of subsections (b) and (c) shall not apply if the aggregate amount of the payment adjustments under the plan for disproportionate share hospitals (as defined under the State plan) is not less than the aggregate amount of payment adjustments otherwise required to be made if such subsections applied, and

''(B) subsection (d)(2)(B) shall apply to hospitals located in urban areas, as well as in rural areas.''.

(B) Section 4112 of OBRA is further amended—

(i) by striking ''(a) IMPLEMENTATION OF REQUIREMENT.—'' and inserting the following:

''(a) IN GENERAL.—Title XIX of the Social Security Act is amended—

''(1) by redesignating section 1923 as section 1924, and

''(2) by inserting after section 1922 the following new section:

'' 'ADJUSTMENT IN PAYMENT FOR INPATIENT HOSPITAL SERVICES FURNISHED BY DISPROPORTIONATE SHARE HOSPITALS

'' 'SEC. 1923. (a) IMPLEMENTATION OF REQUIREMENT.—' '';

(ii) in subsection (a)(1), by striking ''A State's plan under title XIX of the Social Security Act'' and inserting ''A State plan under this title'';

(iii) in subsection (a)(1), by striking ''of such Act'';

(iv) in subsection (a), by striking ''of Health and Human Services'' each place it appears;

(v) in the matter following paragraph (2)(B) of subsection (a), by striking ''of the Social Security Act'';

(vi) in subsections (b) and (c), by striking ''under title XIX of the Social Security Act'' each place it appears and inserting ''under this title'';

(vii) in subsection (d)(2)(B), by striking ''of the Social Security Act'';

(viii) in subsections (b)(2), (b)(3), and (d)(2)(B), by striking double quotation marks enclosing terms and inserting single quotation marks;

(ix) by placing opening double quotation marks at the beginning of any matter with an initial paragraph indentation (beginning with subsection (a)(1)) and closing double quotation marks at the end of subsection (e); and

(x) by adding at the end the following:

"(b) CONFORMING AMENDMENT.—Section 1903(i)(3) of such Act (42 U.S.C. 1396b(i)(3)) is amended by inserting '(other than amounts attributable to the special situation of a hospital which serves a disproportionate number of low income patients with special needs)' before 'to the extent'.".

(7) SECTION 4113.—Section 4113 of OBRA is amended—

(A) in the matter inserted by subsection (a)(1)(B)—

(i) by moving the left margin of the matter 2 ems to the left, and

(ii) by striking "subparagraph (G)" and inserting "subparagraph (E) or (G)";

(B) in the matter inserted by subsection (a)(2), by striking "paragraph (2)(G) or (6)" and inserting "paragraph (2)(B)(iii), (2)(E), (2)(G), or (6)";

(C) in subsection (b)(2)(ii), by striking "such"; and

(D) by striking subsection (d) and redesignating subsection (e) as subsection (d).

(8) SECTION 4114.—(A) Section 4114 of OBRA is amended in paragraph (1), by striking " '(1)' " and inserting " '(o)(1)' ".

(B) Section 1905(o)(1)(B) of the Social Security Act, as added by section 4114(3) of OBRA, is amended—

(i) by striking "only", and

(ii) by striking "immunodeficiency syndrome" and inserting "immune deficiency syndrome (AIDS)".

(9) SECTION 4115.—(A) Section 4115 of OBRA is amended—

(A) in subsection (b)(4)(B), by striking "program" and inserting "Program",

(B) in subsection (c)—

(i) by inserting "under section 9121 of this Act" after "Upon approval", and

(ii) by striking "1916, and 1924" and inserting "1902(e)(1), and 1916", and

(C) by adding at the end the following:

"(d) EXTENSION OF TEXAS STATE WAIVER.—Section 9523(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking 'January 1, 1989' and inserting 'January 1, 1990'.".

(10) SECTION 4118.—(A) Section 1915(c)(10) of the Social Security Act, as added by section 4118(b) of OBRA, is amended—

(i) by striking "No waiver under this subsection shall limit by an amount less than 200" and inserting "The Secretary shall not limit to fewer than 200", and

(ii) by striking "under such waiver" and inserting "under a waiver under this subsection".

(B) Section 4118(e) of OBRA is amended—

(i) in paragraph (3), by striking "amendment" and inserting "amendments", and

(ii) in paragraph (1)—

(I) by inserting "(A)" after "(1)",

(II) by striking "1128A(a)(1)" and "1320a-7(a)(1))" and inserting "1128(a)" and "1320a-7(a))", respectively, and

(III) by adding at the end the following:

"(B) Section 1128A of such Act is amended by adding at the end the following new subsection:

" '(l) A principal is liable under this section for the actions of the principal's agent acting within the scope of the agency.'.".

(C) Section 1128(d)(3)(B)(ii) of the Social Security Act, as added by section 4118(e)(2)(B) of OBRA, is amended by striking "under a program".

(D) Section 4118(e) of OBRA is amended by redesignating paragraph (3) as paragraph (14) and by inserting after paragraph (2) the following new paragraphs:

"(3) Section 1128(b)(8)(A)(i) of such Act is amended by inserting after '(A)(i)' the following: 'who has a direct or indirect ownership or control interest of 5 percent or more in the entity or'.

"(4) Section 1128(d) of such Act is amended—

"(A) in paragraph (1), by striking 'subsection (b)' and inserting 'this section and section 1128A', and

"(B) in paragraph (3)(A), by striking 'under a program'.'

"(5) Section 1128(i) of such Act is amended—

"(A) in the matter before paragraph (1), by striking 'a physician or other individual' and inserting 'an individual or entity',

"(B) in paragraphs (1) through (4), by striking 'physician or other individual' each place it appears and inserting 'individual or entity', and

"(C) in paragraph (4), by striking 'first offender or other program' and inserting 'first offender, deferred adjudication, or other arrangement or program'.

"(6) Section 1128A(a)(1)(D) of such Act is amended—

"(A) by striking 'excluded under' and inserting 'excluded from', and

"(B) by inserting 'or as a result of the application of the provisions of section 1842(j)(2) or section 1867(d)(2)' after 'or 1866(b)'.

"(7) The second sentence of section 1128A(c)(1) of such Act is amended—

"(A) by inserting ', request for payment, or other occurrence described in this section' after 'any claim', and

"(B) by inserting ', the request for payment was made, or the occurrence took place' after 'claim was presented'.

"(8) Section 1128A(i) of such Act is amended, in the matter before paragraph (1), by striking 'subsection' and inserting 'section'.

"(9) Section 1128A(i)(1) of such Act is amended by inserting 'or title XX' after 'title V'.

"(10) Section 1128A of such Act is further amended—

"(A) in the matter in subsection (a) before paragraph (1), by inserting ', but excluding a beneficiary, as defined in subsection (i)(5)' after 'other entity';

"(B) in subsection (i)(2), by striking 'submitted by' and all that follows through the end and inserting 'for payments for items and services under title V, XVIII, XIX, or XX of this Act.', and

"(C) by adding at the end the following new paragraph:

" '(5) The term "beneficiary" means an individual who is eligible to receive items or services for which payment may be made under title V, XVIII, XIX, or XX but does not include a provider, supplier, or practitioner.'.

"(11) Section 1903(i)(2) of such Act (42 U.S.C. 1396b(i)(2)) is amended—

"(A) in subparagraph (A), by striking 'in the State plan under this title pursuant to section 1128 or section 1128A' and inserting 'under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, 1842(j)(2), or 1867(d)(2)', and

"(B) in subparagraph (B), by striking 'pursuant to section 1128 or section 1128A from participation in the program under this title' and inserting 'from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, 1842(j)(2), or 1867(d)(2)'.

"(12) Section 504(b)(6) of such Act (42 U.S.C. 704(b)(6)) is amended by striking 'pursuant to section 1128 or section 1128A from participation in the program under this title' each place it appears and inserting 'under this title or title XVIII, XIX, or XX pursuant to section 1128, 1128A, 1156, 1842(j)(2), or 1867(d)(2)'.

"(13) Section 2005(a)(9) of such Act (42 U.S.C. 1397d(a)(9)) is amended by striking 'pursuant to section 1128 or section 1128A from participation in the program under this title' each place it appears and inserting 'under this title or title V, XVIII, or XIX pursuant to section 1128, 1128A, 1156, 1842(j)(2), or 1867(d)(2)'.".

(E) Section 4118(f)(1) of OBRA is amended by striking "4111(g)(8)" and inserting "4211(h)(8)".

(F) Section 4118(g)(1)(B) of OBRA is amended by striking "insert" and inserting "inserting".

(G) Section 4118(h) of OBRA is amended—

(i) by inserting a dash after "EXPENSES.";

(ii) in paragraph (1), by striking "Section 1902(a)(17) of the Social Security Act (42 U.S.C. 1396a(a)(17)) is amended" and inserting "Sections 1902(a)(17) and 1903(f)(2) of the Social Security Act (42 U.S.C. 1396a(a)(17), 1396b(f)(2)) are each amended";

(iii) in paragraph (2), by striking "(2) The amendment made by paragraph (1)" and inserting "(3) The amendments made by this subsection", and

(iv) by inserting after paragraph (1) the following new paragraph:

"(2) The first sentence of section 1902(f) of such Act (42 U.S.C. 1396a(f)) is amended by inserting after 'as recognized under State law' the following: 'regardless of whether such expenses are reimbursed under another public program of the State or political subdivision thereof'.".

(H) Section 1915(c)(7)(B) of the Social Security Act, as added by section 4118(k) of OBRA, is amended by inserting before the period at the end the following: ", without regard to the availability of beds for such inpatients".

(I) Section 4118(l)(1) of OBRA is amended by inserting ", as redesignated by section 4102(a)," after "1396n(h))".

(J) Section 9414(b)(3) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 4118(o)(1)(C) of OBRA, is amended by striking "nonfarm".

(K) Section 4118(o)(2)(A) of OBRA is amended by inserting "each place it appears" before "and inserting".

(L) Section 4118(p)(9) of OBRA is amended by striking "1925(a)" and "(4111(a))" and inserting "1923(a)" and "4211(a)", respectively.

(M) Section 4118(p) of OBRA is amended by adding at the end the following new paragraph:

"(11) Paragraph (5) of section 9432(c) of the Omnibus Budget Reconciliation Act of 1986 is amended to read as follows:

" '(5) The Secretary shall submit an interim report on the results of the study, including an analysis of the geographic variations under paragraph (2), to the Congress not later than January 1, 1990, and shall report the final results of the study to the Congress not later than January 1, 1992.'.".

(11) OMITTED SECTION.—(A) Part 2 of subtitle B of title IV of OBRA is amended by adding at the end the following new section:

"SEC. 4119. STUDY OF MEANS OF RECOVERING COSTS OF NURSING FACILITY SERVICES FROM ESTATES OF BENEFICIARIES.

"The Secretary of Health and Human Services shall study the means of recovering amounts from estates of deceased medicaid beneficiaries (or the estates of the spouses of such deceased beneficiaries) to pay for the medical assistance for skilled nursing facility or intermediate care facility services furnished, under title XIX of the Social Security Act, to such medicaid beneficiaries. The Secretary shall report to Congress, not later than December 31, 1988, on such means, and include appropriate recommendations for changes in legislation.".

(B) The table of contents of title IV of OBRA is amended by inserting after the item relating to section 4118 the following new item:

"Sec. 4119. Study of means of recovering costs of nursing facility services from estates of beneficiaries.".

(12) MEDICAID CONFORMING AMENDMENT TO SECTION 4014 OF OBRA.—(A) Paragraph (5) of section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)) is amended to read as follows:

"(5)(A) If the Secretary determines that an entity with a contract under this subsection—

"(i) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

"(ii) imposes premiums on individuals enrolled under this subsection in excess of the premiums permitted under this title;

"(iii) acts to discriminate among individuals in violation of the provision of paragraph (2)(A)(v), including expulsion or refusal to re-enroll an individual or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this subsection) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services; or

"(iv) misrepresents or falsifies information that is furnished—

"(I) to the Secretary or the State under this subsection, or

"(II) to an individual or to any other entity under this subsection,

the Secretary may provide, in addition to any other remedies available under law, for any of the remedies described in subparagraph (B).

"(B) The remedies described in this subparagraph are—

"(i) civil money penalties of not more than $25,000 for each determination under subparagraph (A), or, with respect to a determination under clause (iii) or (iv)(I) of such subparagraph, of not more than $100,000 for each such determination, plus, with respect to a determination under subparagraph (A)(ii), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under subparagraph (A)(iii), $15,000 for each individual not enrolled as a result of a practice described in such subparagraph, or

"(ii) denial of payment to the State for medical assistance furnished under the contract under this subsection for individuals enrolled after the date the Secretary notifies the organization of a determination under subparagraph (A) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).".

(B) The amendment made by subparagraph (A) shall apply to actions occurring on or after the date of the enactment of this Act.

(13) TREATMENT OF EDUCATIONALLY-RELATED SERVICES.—(A) Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by inserting after subsection (b) the following new subsection:

"(c) Nothing in this title shall be construed as prohibiting or restricting, or authorizing the Secretary to prohibit or restrict, payment under subsection (a) for medical assistance for covered services furnished to a handicapped child because such services are included in the child's individualized education program established pursuant to part B of the Education of the Handicapped Act or furnished to a handicapped infant or toddler because such services are includ-

ed in the child's individualized family service plan adopted pursuant to part H of such Act.".

(B) The amendment made by subparagraph (A) shall take effect on the date of the enactment of this Act.

(14) CLARIFICATION OF TERM "INSTITUTION FOR MENTAL DISEASES".—(A) Section 1905 of the Social Security Act (42 U.S.C. 1396d) is amended by inserting after subsection (h) the following new subsection:

"(i) The term 'institution for mental diseases' means a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.".

(B) The amendment made by subparagraph (A) shall take effect on the date of the enactment of this Act.

(15) ELIGIBILITY VERIFICATION TECHNICAL CORRECTION.—(A) Section 1137 of the Social Security Act (42 U.S.C. 1320b-7) is amended by adding at the end the following new subsection:

"(f) Subsections (a)(1) and (d) shall not apply with respect to aliens seeking medical assistance for the treatment of an emergency medical condition under section 1903(v)(2).".

(B) The amendment made by subparagraph (A) shall apply as if it were included in the enactment of section 9406 of the Omnibus Budget Reconciliation Act of 1986.

(16) TECHNICAL CORRECTIONS RELATING TO PRESUMPTIVE ELIGIBILITY.—(A) Section 1920(d)(1)(B) of the Social Security Act (42 U.S.C. 1396r-1(d)(1)(B)) is amended by striking "by a qualified provider" and inserting "by a provider that is eligible for payments under the State plan".

(B) Section 1920(b)(2)(D) of such Act (42 U.S.C. 1396r-1(b)(2)(D)) is amended—

(i) in clause (i)—

(I) in subclause (I), by striking "or section 330" and inserting ", 330, or 340" and by striking "or" at the end,

(II) in subclause (II), by striking the semicolon at the end and inserting ", or", and

(III) by adding after subclause (II) the following new subclause:

"(III) title V of the Indian Health Care Improvement Act;";

(ii) in clause (ii), by striking "or" at the end; and

(iii) by adding at the end the following new clause:

"(iv) is the Indian Health Service or is a health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act (Public Law 93-638).".

(C) The amendments made by this paragraph shall be effective as if they were included in section 9407(b) of the Omnibus Budget Reconciliation Act of 1986.

(17) WAIVER FOR CHILDREN INFECTED WITH AIDS OR DRUG DEPENDENT AT BIRTH.—(A) Section 1915 of the Social Security Act (42 U.S.C. 1396n) is amended—

(i) by redesignating subsection (f) as paragraph (2),

(ii) in subsection (e), by striking paragraph (2) and by redesignating such subsection as subsection (f),

(iii) by inserting after subsection (d) the following new subsection:

"(e)(1)(A) Subject to paragraph (2), the Secretary shall grant a waiver to provide that a State plan approved under this title shall include as 'medical assistance' under such plan payment for part or all of the cost of nursing care, respite care, physicians' services, prescribed drugs, medical devices and supplies, transportation services, and such other services requested by the State as the Secretary may approve which are provided pursuant to a written plan of care to a child described in subparagraph (B) with respect to whom there has been a determination that but for the provision of such services the infants would be likely to require the level of care provided in a hospital or nursing facility the cost of which could be reimbursed under the State plan.

"(B) Children described in this subparagraph are individuals under 5 years of age who—

"(i) at the time of birth were infected with (or tested positively for) the etiologic agent for acquired immune deficiency syndrome (AIDS),

"(ii) have such syndrome, or

"(iii) at the time of birth were dependent on heroin, cocaine, or phencyclidine,

and with respect to whom adoption or foster care assistance is (or will be) made available under part E of title IV.

"(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

"(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

"(B) under such waiver the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to such individuals does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the State plan for such individuals if the waiver had not been granted; and

"(C) the State will provide to the Secretary annually, consistent with a data collection plan designed by the Secretary, information on the impact of the waiver granted under this subsection on the type and amount of medical assistance provided under the State plan and on the health and welfare of recipients.

"(3) A waiver granted under this subsection may include a waiver of the requirements of section 1902(a)(1) (relating to statewideness) and section 1902(a)(10)(B) (relating to comparability). A waiver under this subsection shall be for an initial term of 3 years and, upon the request of a State, shall be extended for additional five-year periods unless the Secretary determines that for the previous waiver period the assurances provided under paragraph (2) have not been met.

"(4) The provisions of paragraph (6) of subsection (d) shall apply to this subsection in the same manner as it applies to subsection (d).''; and

(iv) in subsection (h), by striking "or (d)" and inserting "(d), or (e)".

(B) Section 1902(a)(10)(A)(ii)(VI) of such Act (42 U.S.C. 1396a(a)(10)(A)(ii)(VI)) is amended by striking "(c) or (d)" each place it appears and inserting "(c), (d), or (e)".

(l) CORRECTIONS RELATING TO SUBTITLE C OF TITLE IV (NURSING HOME REFORM).—

(1) SECTION 4201.—(A) Section 1819 of the Social Security Act, as added by section 4201(a)(3) of OBRA, is amended—

(i) in subsection (b)(3)(C)(i)(I), by striking "October 1, 1990" the second place it appears and inserting "January 1, 1991";

(ii) in subsection (b)(4)(C)(i)—

(I) by inserting "licensed" after "24-hour",

(II) by striking "employ" and inserting "use", and

(III) by striking "during the day tour of duty (of at least 8 hours a day)" and inserting "at least 8 consecutive hours a day,";

(iii) in subsection (b)(5)(A), by striking "October 1, 1989" and all that follows through "July 1, 1989)" and inserting "January 1, 1990";

(iv) in subsection (e)(1)(A), by striking "March 1, 1989" and inserting "January 1, 1989";

(v) in subsection (e)(1)(B), by striking "March 1, 1990" and inserting "January 1, 1990";

(vi) in subsection (e)(2)(A), by striking "March 1, 1989" and inserting "January 1, 1989";

(vii) in subsection (e)(3), by striking "October 1, 1990" and inserting "October 1, 1989";

(viii) in subsection (e)(5), by striking "July 1, 1989" and inserting "July 1, 1990";

(ix) in subsection (f)(3), by striking "October 1, 1989" and inserting "October 1, 1988";

(x) in subsection (f)(6)(A), by striking "July 1, 1989" and inserting "January 1, 1989"; and

(xi) in subsection (f)(6)(B), by striking "October 1, 1990" and inserting "April 1, 1990".

(B) Section 4201(d) of OBRA is amended—

(i) by striking "AMENDMENT.—" and inserting "AMENDMENTS.—(1)",

(ii) by striking "1919(a)(2)" and inserting "1819(a)(1)", and

(iii) by adding at the end the following new paragraph:

"(2) Section 1861(n) of such Act (42 U.S.C. 1395x(n)) is amended by striking 'or (j)(1) of this section' and inserting 'or of section 1819(a)(1)'.".

(2) SECTIONS 4201 AND 4211.—(A) Sections 1819(b)(3)(A)(iv) and 1919(b)(3)(A)(iv) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are amended by striking "in the case of a resident eligible for benefits under part A of this title" and by striking "in

the case of a resident eligible for benefits under part A of title XVIII", respectively.

(B) Sections 1819(b)(3)(A)(iii) and 1919(b)(3)(A)(iii) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are amended by striking "in the case of a resident eligible for benefits under title XIX," and "in the case of a resident eligible for benefits under this title,", respectively.

(C) Subclause (III) of each of sections 1819(b)(3)(B)(ii) and 1919(b)(3)(B)(ii) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, is amended to read as follows:

> *"(III) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).".*

(D) Sections 1819(b)(5) and 1919(b)(5) of the Social Security Act, as added by section 4201(a)(3) of OBRA and as inserted by section 4211(a)(3) of OBRA, respectively, are each amended—

(i) in subparagraph (A), by striking ", who is not a licensed health care professional (as defined in subparagraph (E))",

(ii) in subparagraph (A)(ii), by striking "such services" and inserting "nursing or nursing-related services", and

(iii) in subparagraph (G), by inserting "physical or occupational therapy assistant," after "occupational therapist,".

(E) Effective as of the date of the enactment of this Act and until the effective date of section 1819(c) of such Act, section 1861(j) of the Social Security Act is deemed to include the requirement described in section 1819(c)(3)(A) of such Act (as added by section 4201(a)(3) of OBRA).

(F) Sections 1819(c)(2)(A)(v) and 1919(c)(2)(A)(v) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are each amended by striking "an allowable charge" and all that follows through the semicolon and inserting "for a stay at the facility;".

(G) Sections 1819(c)(6) and 1919(c)(6) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are each amended—

(i) in subparagraph (A)(ii), by striking "once the facility accepts" and inserting "upon", and

(ii) in subparagraph (B), by striking "a facility's acceptance of".

(H) Sections 1819(e)(2)(B) and 1919(e)(2)(B) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively are each amended by inserting after the first sentence the following sentence: "The State shall make available to the public information in the registry.".

(I) Sections 1819(e)(3), 1819(f)(3), 1919(e)(3), and 1919(f)(3) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are each amended—

(i) by inserting "AND DISCHARGES" after "TRANSFERS", and

(ii) by inserting "and discharges" after "transfers".

(J) Sections 1819(f)(2)(A)(i)(I) and 1919(f)(2)(A)(i)(I) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are each amended by striking "cognitive, behavioral and social care" and inserting "recognition of mental health and social service needs".

(K) Sections 1819(f)(7) and 1919(f)(7) of the Social Security Act, as added by section 4201(a)(3) and as inserted by section 4211(a)(3) of OBRA, respectively, are each amended by striking "patients" and inserting "residents".

(L)(i) Section 1819(f)(7)(B) of the Social Security Act, as added by section 4201(a)(3), is amended by striking "shall not" and inserting "shall".

(ii) Section 1919(f)(7)(B) of the Social Security Act, as inserted by section 4211(a)(3) of OBRA, is amended by striking "do not".

(3) SECTION 4211.—(A) Section 1919(b)(4)(C) of the Social Security Act, as inserted by section 4211(a) of OBRA, is amended—

(i) by striking "registered nurse" each place it appears and inserting "registered professional nurse";

(ii) by striking "employ" and inserting "use";

(iii) by striking "(ii) FACILITY WAIVERS.—" and all that follows through "(i) WAIVER" and inserting "(ii) WAIVER";

(iv) by striking "and subject to clause (ii)" and inserting "and subject to clause (iii)";

(v) by striking "(ii) ASSUMPTION" and inserting "(iii) ASSUMPTION"; and

(vi) in clause (iii), as so redesignated, by striking "excercise" and inserting "exercise".

(B) Section 1919(b)(5)(A) of the Social Security Act, as added by section 4211(a)(3) of OBRA, is amended by striking "subparagraph (E)" and inserting "subparagraph (F)".

(C) Effective as of the date of the enactment of this Act and until the effective date of section 1919(c) of such Act, section 1905(c) of the Social Security Act is deemed to include the requirement described in section 1919(c)(3)(A) of such Act (as inserted by section 4211(a)(3) of OBRA).

(D) Section 1919 of the Social Security Act, as inserted by section 4211(a)(3) of OBRA, is amended—

(i) in subsection (e)(1)(A), by striking "September 1, 1988" and inserting "January 1, 1989";

(ii) in subsection (e)(1)(B), by striking "September 1, 1990" and inserting "January 1, 1990";

(iii) in subsection (e)(7)(E), by striking "October 1, 1988" and inserting "April 1, 1989"; and

(iv) in subsection (f)(2), by striking "July 1, 1988" and inserting "September 1, 1988".

(E) Section 1902(a)(28)(D)(i) of the Social Security Act, as amended by section 4211(b)(1)(B) of OBRA, is amended by striking "1919(f)" and all that follows through "instrument)" and inserting "1919(e)".

(F) Section 4211(d)(2) of OBRA is amended by striking "For calendar quarters during fiscal years 1988 and 1989" and in-

serting "For the 8 calendar quarters (beginning with the calendar quarter that begins on July 1, 1988)".

(G) Section 4211(h)(10)(G) of OBRA is amended by adding before the period at the end the following: ", and by striking 'skilled nursing facility or intermediate care facility' in subparagraph (B) and inserting 'nursing facility' ".

(H) Section 4211(h)(2) of OBRA is amended—

(i) in subparagraph (C), by striking "inserting 'nursing facilities' " each place it appears and inserting "inserting 'nursing facilities and for intermediate care facilities for the mentally retarded' ",

(ii) in subparagraph (D)(i), by striking "inserting 'nursing facility' " and inserting "inserting 'nursing facility or intermediate care facility for the mentally retarded' ", and

(iii) in subparagraph (D)(ii), by striking "inserting 'nursing facility' " and inserting "inserting 'nursing facility services or services in an intermediate care facility for the mentally retarded' ".

(I) Subparagraph (B) of section 4211(h)(12) of OBRA is amended to read as follows:

"(B) in subsection (c)(2)(B)(ii), by striking 'skilled' each place it appears.".

(4) SECTION 4202.—Section 1819(g)(2)(C)(i) of the Social Security Act, as added by section 4202(a) of OBRA, is amended by striking "October 1, 1990" and inserting "January 1, 1990".

(5) SECTIONS 4202 AND 4212.—Sections 1819(g) and 1919(g) of the Social Security Act, as added by sections 4202(a)(2) and 4212(a) of OBRA, respectively, are amended—

(A) in paragraph (1)(C), by striking ", review," and inserting "and timely review";

(B) in the first sentence of paragraph (1)(C), by inserting "or by another individual used by the facility in providing services to such a resident" after "a nursing facility";

(C) by striking the second sentence of paragraph (1)(C) and inserting the following: "The State shall, after notice to the individual involved and a reasonable opportunity for a hearing for the individual to rebut allegations, make a finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the appropriate licensure authority.";

(D) in paragraph (1)(D), by striking "to establish standards under subsection (f)" and inserting "to issue regulations to carry out this subsection";

(E) in paragraph (2)(A)(i), by amending the third sentence to read as follows: "The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).";

(F) in paragraph (3)(D) (relating to special surveys of compliance, as redesignated by paragraph (6)(A) in the case of section 1919(g)), by striking "on that basis" and inserting "on the basis of that survey"; and

(G) in paragraph (4), by striking "chronically".

(6) SECTION 4212.—(A) Section 1919(g)(3) of the Social Security Act, as added by section 4212(a) of OBRA, is amended by redesignating the second subparagraph (C) (relating to special surveys of compliance) as subparagraph (D).

(B) Section 4212(b) of OBRA is amended to read as follows:

"(b) POSTING SURVEY RESULTS.—Section 1919(c) of such Act is amended by adding at the end the following new paragraph:

" '(7) POSTING OF SURVEY RESULTS.—A nursing facility must post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility conducted under subsection (g).'.".

(C) Section 1902(a)(33)(B) of the Social Security Act, as amended by section 4212(d)(3) of OBRA, is amended by striking "1919(d)" and inserting "1919(g)".

(D) Section 4212(e)(1)(B) of OBRA is amended by inserting "provided" after "services" each place it appears.

(E) Section 4212(e) of OBRA is amended by adding at the end the following new paragraph:

"(5) Section 1922(e) of such Act, as redesignated and transferred by section 4211(a)(2) of this Act, is amended by striking '1910(c)' in paragraphs (1) and (2)(A) and inserting '1910(b)'.".

(7) SECTIONS 4203 AND 4213.—(A) Sections 1819(h)(2)(B)(ii) and 1919(h)(3)(C)(ii) of the Social Security Act, as added sections 4203(a)(2) and 4213(a) of OBRA, respectively, are each amended by striking "and the Secretary" and all that follows through "1128A." and inserting the following: ". The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).".

(B) Sections 1819(h)(6) and 1919(h)(9) of the Social Security Act, as added by sections 4203(a)(2) and 4213(a) of OBRA, respectively, are each amended by inserting "by such facilities" after "shall be made available".

(8) SECTION 4213.—(A) Section 4213(a) of OBRA is amended by striking "as inserted by section 4201 and amended by section 4202" and inserting "as inserted by section 4211 and amended by section 4212".

(B) Section 1919(h) of the Social Security Act, as added by section 4213(a) of OBRA, is amended—

(i) in the last sentence of paragraph (1), by striking "(2)(A)(i)" and inserting "(2)(A)(ii)",

(ii) in the second sentence of paragraph (2)(B)(i), by striking "or otherwise", and

(iii) in paragraph (5), by striking "State and the Secretary" and inserting "State or the Secretary, respectively".

(C) Paragraph (1) of section 4213(b) of OBRA is amended by striking "1902" and all that follows through the end and in-

serting the following: "1902(i) of such Act (42 U.S.C. 1396a(i)) is amended—

"(A) in paragraph (1), by striking 'skilled nursing facility or intermediate care facility' and inserting 'intermediate care facility for the mentally retarded';

"(B) in paragraph (1), by striking 'the provisions of section 1861(j) or section 1905(c), respectively,' and inserting 'the requirements for such a facility under this title'; and

"(C) in paragraphs (2) and (3), by striking 'the provisions of section 1861(j) or section 1905(c) (as the case may be)' and inserting 'the requirements for such a facility under this title'.".

(9) SECTION 4204.—(A) Section 4204(a) of OBRA is amended by striking "extended care".

(B) Section 4204 of OBRA is amended—

(i) in subsection (a), by striking "made by this part" and inserting "made by sections 4201 and 4202 (relating to skilled nursing facility requirements and survey and certification requirements)",

(ii) by redesignating subsection (c) as subsection (d), and

(iii) by inserting after subsection (a) the following new subsection:

"(b) ENFORCEMENT.—(1) Except as otherwise specifically provided in section 1819 of the Social Security Act, the amendments made by section 4203 of this Act apply January 1, 1988, without regard to whether regulations to implement such amendments are promulgated by such date.

"(2) In applying the amendments made by section 4203 of this Act for services furnished by a skilled nursing facility before October 1, 1990, any reference to a requirement of subsection (b), (c), or (d), of section 1819 of the Social Security Act is deemed a reference to the provisions of section 1861(j) of such Act.".

(10) SECTION 4214.—Section 4214 of OBRA is amended—

(A) by striking "(c) TRANSITIONAL RULE.—" and inserting "(2)",

(B) by inserting "of section 1919 of the Social Security Act" after "(b), (c), or (d)", and

(C) by redesignating subsection (d) as subsection (c).

(m) CORRECTIONS TO SUBTITLE E OF TITLE IV (RELATING TO RURAL HEALTH).—

(1) SECTION 4401.—Section 711(b)(1) of the Social Security Act, as added by section 4401 of OBRA, is amended by striking "section 4083 of the Omnibus Budget Reconciliation Act of 1987" and inserting "section 4403 of the Omnibus Budget Reconciliation Act of 1987 (as such section pertains to rural health issues)".

(2) SECTION 4403.—(A) Section 4403 of OBRA is amended—

*(i) in the heading, by striking "**EXPERIMENTS AND DEMONSTRATION PROJECTS RELATING TO RURAL HEALTH CARE ISSUES**" and inserting "**RESEARCH AND DEMONSTRATION PROJECTS ON RURAL AND INNER-CITY HEALTH ISSUES**";*

(ii) in subsection (a)—

(I) by striking "SET ASIDE.—" and inserting "SET ASIDES FOR ISSUES OF HEALTH CARE IN RURAL AREAS AND IN INNER-CITY AREAS.—(1)",

(II) by striking "expended in each fiscal year" and all that follows through "1972" and inserting "annually appropriated to, and expended by, the Health Care Financing Administration for the conduct of research and demonstration projects in fiscal years 1988, 1989, and 1990",

(III) by striking "experiments" and inserting "research";

(iii) by adding at the end the following new paragraph:

"(2) Not less than ten percent of the total amounts annually appropriated to, and expended by, the Health Care Financing Administration for the conduct of research and demonstration projects in fiscal years 1988, 1989, and 1990 shall be expended for research and demonstration projects relating exclusively or substantially to issues of providing health care in inner-city areas, including (but not limited to) the impact of the payment methodology under section 1886(d) of the Social Security Act on the financial viability of inner-city hospitals and the impact of medicare policies on access to (and the quality of) health care in inner-city areas."; and

(iv) in subsection (b)—

(I) by striking "of experiments" and inserting "of research",

(II) by inserting "or to inner-city health issues" after "rural health issues", and

(III) by striking "experiments and".

(B) The item in the table of contents of OBRA relating to section 4403 is amended to read as follows:

"Sec. 4403. Set aside for research and demonstration projects on rural and inner-city health issues.".

(n) CORRECTIONS TO CERTAIN HEALTH-RELATED PROVISIONS IN TITLE IX.—

(1) SECTION 9010.—The last sentence of section 226(b) of the Social Security Act, as added by section 9010(e)(3) of OBRA, is amended to read as follows: "In determining when an individual's entitlement or status terminates for purposes of the preceding sentence, the term '36 months' in the second sentence of section 223(a)(1), in section 202(d)(1)(G)(i), in the last sentence of section 202(e)(1), and in the last sentence of section 202(f)(1) shall be applied as though it read '15 months'.".

(2) SECTION 9115.—Section 9115(b) of OBRA is amended by striking "1902(l)" and inserting "1902(o)".

(3) SECTION 9119.—Section 9119 of OBRA is amended by adding at the end the following new subsection:

"(d) CONFORMING AMENDMENTS TO MEDICAID PROGRAM FOR THE MEDICALLY NEEDY.—(1) Section 1902 of the Social Security Act (42 U.S.C. 1396a) is amended—

"(A) in subsection (a)—

"(i) by striking 'and' at the end of paragraph (48),

"(ii) by striking the period at the end of paragraph (49) and inserting '; and', and

"(iii) by inserting after paragraph (49) the following new paragraph:

" '(50) provide, in accordance with subsection (q), for a monthly personal needs allowance for certain institutionalized individuals and couples.'; and

"(B) by adding at the end the following new subsection:

" '(q)(1)(A) In order to meet the requirement of subsection (a)(50), the State plan must provide that, in the case of an institutionalized individual or couple described in subparagraph (B), in determining the amount of the individual's or couple's income to be applied monthly to payment for the cost of care in an institution, there shall be deducted from the monthly income (in addition to other allowances otherwise provided under the State plan) a monthly personal needs allowance—

" '(i) which is reasonable in amount for clothing and other personal needs of the individual (or couple) while in an institution, and

" '(ii) which is not less (and may be greater) than the minimum monthly personal needs allowance described in paragraph (2).

" '(B) In this subsection, the term "institutionalized individual or couple" means an individual or married couple—

" '(i) who is an inpatient (or who are inpatients) in a medical institution or nursing facility for which payments are made under this title throughout a month, and

" '(ii) who is or are determined to be eligible for medical assistance under the State plan.

" '(2) The minimum monthly personal needs allowance described in this paragraph is $30 for an institutionalized individual and $60 for an institutionalized couple (if both are aged, blind, or disabled, and their incomes are considered available to each other in determining eligibility).'.

"(2) The amendments made by paragraph (1) apply to payments under title XIX of the Social Security Act for calendar quarters beginning on or after July 1, 1988, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.".

(o) SUBTITLE D OF TITLE IV.—

(1) SECTION 4303.—Section 2115 of the Public Health Service Act—

(A) in subsection (i)(1), as added by section 4303(a) of OBRA, is amended by striking "from appropriations under subsection (i)" and inserting "by the Secretary from appropriations under subsection (j)", and

(B) in subsection (j), as added by section 4303(b) of OBRA, is amended by inserting "to the Department of Health and Human Services" after "to be appropriated".

(2) SECTION 4307.—Section 4307(3)(C) of OBRA is amended by striking "subsection (g)" and inserting "subsection (e), as redesignated by section 4303(d)(2)(A),".

(3) SECTION 4308.—(A) Subtitle D of title IV of OBRA is amended by adding at the end the following new section:

"SEC. 4308. TECHNICAL AMENDMENTS RELATING TO COURT OF CLAIMS PROCEDURES.

"(a) DUTIES OF SPECIAL MASTERS.—Section 2112(c)(2) of the Public Health Service Act (42 U.S.C. 300aa-12(a)) is amended—

"(1) by inserting ', shall prepare and submit to the court proposed findings of fact and conclusions of law,' after 'adjunct to the court',

"(2) by inserting 'and' at the end of subparagraph (C),

"(3) by striking ', and' at the end of subparagraph (D) and inserting a period, and

"(4) by striking subparagraph (E).

"(b) REQUIRING FILING OF APPEALS WITHIN 60 DAYS.—Section 2112(e) of such Act (42 U.S.C. 300aa-12(e)), as redesignated by section 4303(d)(2)(A), is amended by inserting 'within 60 days of the date of the judgment' after 'petition filed'.

"(c) CLARIFICATION ON TIMING OF BRINGING ADDITIONAL ACTIONS.—The second sentence of section 2121(a) of such Act (42 U.S.C. 300aa-21(a)) is amended by striking 'the entry of the court's judgment' and inserting 'the court's final judgment'.".

(B) The table of contents relating to title IV of OBRA is amended by inserting after the item relating to section 4307 the following new item:

"Sec. 4308. Technical amendments relating to Court of Claims procedures.".

Subtitle C—Miscellaneous Provisions

SEC. 421. MAINTENANCE OF EFFORT.

(a) IN GENERAL.—

(1) DUPLICATIVE PART A BENEFITS.—If an employer described in subsection (b)(1) provides, as of the date of the enactment of this Act, health care benefits to an employee or retired former employee that are duplicative part A benefits (as defined in paragraph (3)(A)), the employer shall, during the period described in subsection (c)(1), provide to the employee or retired former employee an amount of additional benefits or refunds, or combination of such benefits and refunds, that total at least the actuarial value of the duplicative part A benefits during the period described in subsection (c)(1)(A).

(2) DUPLICATIVE PART B BENEFITS.—If an employer described in subsection (b)(2) provides, as of the date of the enactment of this Act, health care benefits to an employee or retired former employee that are duplicative part B benefits (as defined in paragraph (3)(B)), the employer shall, during the period described in subsection (c)(2), provide to the employee or retired former employee an amount of additional benefits or refunds, or combination of such benefits and refunds, that total at least the actuarial value of the duplicative part B benefits during the period described in subsection (c)(1)(B).

(3) DUPLICATIVE BENEFITS DEFINED.—In this section:

(A) The term "duplicative part A benefits" means benefits which are duplicative of benefits under part A of title XVIII of the Social Security Act (as amended by this Act as of January 1, 1989), but which were not duplicative of such

benefits as such part was in effect before the date of the enactment of this Act.

(B) The term "duplicative part B benefits" means benefits which are duplicative of benefits under part B of title XVIII of the Social Security Act (as amended by this Act as of January 1, 1990, but excluding any such benefits with respect to covered outpatient drugs), but which were not duplicative of such benefits as such part was in effect before the date of the enactment of this Act.

(C) Duplicative part A benefits and duplicative part B benefits shall be determined under this section net of any premiums payable by employees (or retired former employees) attributable to the respective duplicative benefits.

(b) EMPLOYERS COVERED.—

(1) DUPLICATIVE PART A BENEFITS.—An employer is described in this paragraph if the employer (including a public employer, other than an employer to which section 422 applies) provides, as of the date of the enactment of this Act, duplicative part A benefits the actuarial value of which is at least 50 percent of the national average actuarial value (discounted to the value as of the date of the enactment of this Act) of the duplicative part A benefits.

(2) DUPLICATIVE PART B BENEFITS.—An employer is described in this paragraph if the employer (including a public employer, other than an employer to which section 422 applies) provides, as of the date of the enactment of this Act, duplicative part B benefits the actuarial value of which is at least 50 percent of the national average actuarial value (discounted to the value as of the date of the enactment of this Act) of the duplicative part B benefits.

(3) ELECTION.—For purposes of this section—

(A) IN GENERAL.—An employer may elect to compute the actuarial value of duplicative part A benefits and duplicative part B benefits either—

(i) on the basis of average actuarial values published by the Secretary under subparagraph (B)(i), or

(ii) on the basis of the actuarial value with respect to that employer, computed using guidelines published by the Secretary under subparagraph (B)(ii).

(B) COMPUTATION OF ACTUARIAL VALUES.—The Secretary of Health and Human Services, before the beginning of each of 4 years (beginning with 1989 for duplicative part A benefits and beginning with 1990 for duplicative part B benefits) shall—

(i) calculate and publish the national average actuarial value of duplicative part A benefits and duplicative part B benefits for 1988 and the year involved, and

(ii) guidelines for employers to use, under subparagraph (A)(ii), in computing the actuarial value of such duplicative benefits with respect to each employer for such years.

The guidelines published under clause (ii) shall include instructions to assist employers in determining whether or not

employers are described in paragraph (1) or (2) of this subsection.

(c) EFFECTIVE PERIOD.—

(1) IN GENERAL.—

(A) DUPLICATIVE PART A BENEFITS.—Subsection (a)(1) shall only be effective during the period beginning on January 1, 1989, and ending on December 31, 1989, or, if later, the date specified in paragraph (2).

(B) DUPLICATIVE PART B BENEFITS.—Subsection (a)(2) shall only be effective during the period beginning on January 1, 1990, and ending on December 31, 1990, or, if later, the date specified in paragraph (2).

(2) EXTENSION TO COVER CURRENT COLLECTIVE BARGAINING AGREEMENTS.—In the case of employees or retired former employees who are provided duplicative part A benefits or duplicative part B benefits under a collective bargaining agreement that is in effect on the date of enactment of this Act, the date specified in this paragraph is the date of the expiration of the agreement (determined without regard to any extension thereof agreed to after the date of the enactment of this Act).

(d) EXCLUSION OF MULTI-EMPLOYER PLANS.—This section shall not apply with respect to duplicative benefits provided under a plan—

(1) to which more than one employer is required to contribute, and

(2) which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer.

SEC. 422. RATE REDUCTION FOR MEDICARE ELIGIBLE FEDERAL ANNUITANTS.

(a) IN GENERAL.—

(1) The Office of Personnel Management shall, in consultation with carriers offering health benefits plans contracted pursuant to section 8902 of title 5, United States Code, reduce the rates charged medicare eligible individuals participating in such health benefit plans, by the amount, prorated for each covered medicare eligible individual, of the estimated cost of medical services and supplies which, but for the amendments made by subtitle A of title I and subtitle A of title II of this Act, would have been payable by such plans.

(2) The reduced rates as provided under paragraph (1), shall apply as of the effective dates of the respective amendments.

(b) AUTHORIZATION OF AVAILABILITY OF EMPLOYEE HEALTH BENEFITS FUND FOR RATE REDUCTION.—Funds in the Employees Health Benefits Fund established under section 8909 of title 5, United States Code, are available without fiscal year limitation for costs incurred by the Office of Personnel Management in making rate reductions provided under this section.

(c) DEFINITION.—For purposes of this section the term "medicare eligible individual" means any annuitant, survivor of an annuitant, or former spouse of an annuitant—

(1) who is—

(A) otherwise eligible for benefits under Chapter 89 of title 5, United States Code;

(B) eligible for benefits under part A of title XVIII of the Social Security Act; and

(C) covered by the insurance program established under part B of such title; and

(2) for whom benefits paid under title XVIII of the Social Security Act are the primary source of health care benefits.

SEC. 423. STUDY AND REPORTS BY THE OFFICE OF PERSONNEL MANAGEMENT ON OFFERING MEDICARE SUPPLEMENTAL PLANS TO FEDERAL MEDICARE ELIGIBLE INDIVIDUALS, AND OTHER CHANGES.

(a) STUDY AND REPORT.—

(1) No later than April 1, 1989, the Director of the Office of Personnel Management shall conduct a study and submit a report to the Committee on Governmental Affairs of the Senate and the Committee on Post Office and Civil Service of the House of Representatives regarding changes to the health benefits program established under chapter 89 of title 5, United States Code, that may be required to incorporate plans designed specifically for medicare eligible individuals and to improve the efficiency and effectiveness of the program.

(2) Any medicare supplemental plan recommended by the Director of the Office of Personnel Management shall not duplicate benefits for which payment may be made under title XVIII of the Social Security Act, however such recommendation—

(A) shall cover expenses which are not payable under such title by reason of deductibles or coinsurance amounts; and

(B) may offer additional reimbursement—

(i) where benefits under such title are limited by fee schedule; and

(ii) for benefits not covered under such title which may be of value to medicare eligible individuals.

(b) FEASIBILITY STUDY AND REPORT.—No later than April 1, 1989, the Director of the Office of Personnel Management shall report to the appropriate committees of the Congress whether it is feasible to adopt such standards as issued by the National Association of Insurance commissioners as required by section 1882 of the Social Security Act (42 U.S.C. 1395ss) for medicare supplemental policies, when providing medicare supplemental plans as a type of health benefits plan available for Federal employees pursuant to chapter 89 of title 5, United States Code.

SEC. 424. BENEFITS COUNSELING AND ASSISTANCE DEMONSTRATION PROJECT FOR CERTAIN MEDICARE AND MEDICAID BENEFICIARIES.

(a) TRAINING AND TECHNICAL ASSISTANCE.—

(1) The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish a demonstration project through an agreement with a private or public nonprofit agency or organization, which demonstrates, to the satisfaction of the Secretary, that its volunteers are adequately trained and competent to render effective benefits counseling and assistance to the elderly, for the purpose of providing train-

ing and technical assistance to prepare volunteers to provide to elderly individuals receiving benefits under title XVIII or XIX of the Social Security Act counseling with respect to eligibility for such benefits and assistance in preparing such documentation as may be required to fully receive such benefits.

(2) In addition to any other forms of technical assistance provided under this subsection, the Secretary is authorized to provide to the project—

(A) material to be used in making elderly persons aware of the availability of assistance under volunteer assistance programs under this section; and

(B) technical materials and publications to be used by such volunteers.

(b) POWERS OF THE SECRETARY.—Under the demonstration project under this section, the Secretary is authorized—

(1) to provide for the training of volunteers, and assist in such training, to insure that volunteers are qualified to provide benefits and counseling assistance (as described in paragraph (1)) to the elderly;

(2) to provide reimbursement to volunteers through the agency or organization for transportation, meals, and other expenses incurred by them in training or providing benefits counseling and assistance under this section, and such other support and assistance as the Secretary determines to be appropriate in carrying out the provisions of this section; and

(3) to provide for the use of services, personnel, and facilities of Federal executive agencies and of State and local public agencies with their consent, with or without reimbursement therefor.

(c) EMPLOYMENT OF VOLUNTEERS.—

(1) Service as a volunteer in the demonstration project carried out under this section shall not be considered service as an employee of the United States. Volunteers under the project shall not be considered Federal employees and shall not be subject to the provisions of law relating to Federal employment, except that the provisions of section 1905 of title 18, United States Code, shall apply to volunteers as if they were employees of the United States.

(2) Amounts received by volunteers serving in any program carried out under this section as reimbursement for expenses are exempt from taxation under chapters 1 and 21 of the Internal Revenue Code of 1986.

(d) DEFINITION.—For purposes of this section, the term "elderly individual" means an individual who has attained the age of 60 years.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, in appropriate parts from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, for fiscal years 1989, 1990, and 1991 such sums as may be necessary to carry out the provisions of this section.

SEC. 425. CASE MANAGEMENT DEMONSTRATION PROJECTS.

(a) IN GENERAL.—Within 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services (in

this section referred to as the "Secretary") shall establish 4 demonstration projects under which an appropriate entity agrees to provide case management services to medicare beneficiaries with selected catastrophic illnesses, particularly those with high costs of health care services. At least one such demonstration project shall be conducted through an agreement with a utilization and quality control peer review organization with a contract with the Secretary under part B of title XI of the Social Security Act.

(b) PURPOSE OF PROJECTS.—It is the purpose of the demonstration projects established under this section to provide the Secretary and the Congress with the information necessary—

(1) to evaluate the appropriateness of providing case management services under the medicare program for medicare beneficiaries with high costs of medical care, and

(2) to determine the most effective approach to implementing a case management system under the program for such beneficiaries.

(c) AGREEMENT.—The agreement entered into under subsection (a) shall specify—

(1) the high cost cases with respect to which case management services will be provided under the project,

(2) the payments to be made to the entity conducting the project for carrying out the project, and

(3) such other terms and conditions as the Secretary and the entity conducting the project may agree to.

(d) WAIVERS.—The Secretary shall waive—

(1) such provisions of part B of title XI of the Social Security Act, and

(2) such provisions of title XVIII of such Act as relate to limitations or restrictions on benefits under such title,

as the Secretary determines to be appropriate for the conduct of demonstration projects under this section.

(e) DURATION.—

(1) Except as provided in paragraph (2), a demonstration project under this section shall be conducted for a 2-year period.

(2) The Secretary may terminate a demonstration project before the end of the 2-year period specified in paragraph (1) if the Secretary determines that the entity conducting the project is not in substantial compliance with the terms of the agreement entered into under subsection (a).

(f) INFORMATION AND REPORTS.—

(1) An entity with an agreement under subsection (a) shall furnish the Secretary with such information as the Secretary determines to be necessary to evaluate the results of that project.

(2)(A) The Secretary shall submit to the Congress an interim report on the projects conducted under this section based upon information that is derived from the first year of project operations and shall set forth any interim findings, recommendations, and conclusions that the Secretary determines to be appropriate.

(B) The Secretary shall submit to the Congress a final report on the demonstration projects conducted under this section based upon data derived from the projects and shall update the

findings, recommendations, and conclusions set forth in the interim report submitted under paragraph (1).

(g) AUTHORIZATION TO USE CERTAIN FUNDS.—The Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Insurance Trust Fund in such proportions as the Secretary determines to be appropriate, of not to exceed $2,000,000 in each of 2 fiscal years for administrative costs in carrying out the demonstration projects under this section. Such amounts shall be transferred without regard to amounts appropriated in advance in appropriation Acts.

SEC. 426. EXTENSIONS OF EXPIRING PROVISIONS.

(a) HOSPICE WAIVER OF LIABILITY PROVISION.—Section 9305(f)(2) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking "November 1, 1988" and inserting "November 1, 1990".

(b) SKILLED NURSING FACILITY WAIVER OF LIABILITY PRESUMPTION.—The second sentence of section 9126(c) of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended—

(1) by striking "30-month", and

(2) by inserting before the period at the end the following: "and ending on October 31, 1990".

(c) HOME HEALTH SERVICES WAIVER OF LIABILITY PRESUMPTION.—Section 9305(g)(3) of the Omnibus Budget Reconciliation Act of 1986 is amended by striking "October 1, 1989" and inserting "November 1, 1990".

(d) HOME HEALTH WAIVER OF LIABILITY PRESUMPTION.—The second sentence of section 9205 of the Consolidated Omnibus Budget Reconciliation Act of 1985 is amended by striking all that follows "until" and inserting "November 1, 1990.".

(e) PROHIBITION ON NEW COST-SAVING REGULATIONS.—Section 4039(d) of the Omnibus Budget Reconciliation Act of 1987 is amended—

(1) by striking "October 15, 1988" and inserting "October 15, 1989", and

(2) by inserting "or in fiscal year 1990" after "in fiscal year 1989".

SEC. 427. ADVISORY COMMITTEE ON MEDICARE HOME HEALTH CLAIMS.

(a) ESTABLISHMENT.—The Administrator of the Health Care Financing Administration (in this section referred to as the "Administrator") shall, within 90 days after the date of the enactment of this Act, establish an advisory committee to be known as the Advisory Committee on Medicare Home Health Claims (in this section referred to as the "Advisory Committee").

(b) MEMBERSHIP.—The Advisory Committee shall be composed of 11 members appointed by the Administrator for the life of the Committee. Of the members appointed—

(1) at least 5 shall be representatives of home health or visiting nurse agencies, and

(2) the remaining members shall be representative of fiscal intermediaries, physician groups, and senior citizen groups, but no more than 3 of such members may be representative of fiscal intermediaries.

Members shall be appointed so as to representative of all geographic areas of the United States.

(c) DUTIES.—The Advisory Committee shall study the reasons for the increase in the denial of claims for home health services during 1986 and 1987, the ramifications of such increase, and the need to reform the process involved in such denials.

(d) REPORT.—The Advisory Committee shall report to the Administrator, the Committees on Ways and Means and Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate, not later than one year after the date of the enactment of this Act, on its study under subsection (c), the findings of its study, and its recommendations for changes in the regulations under title XVIII of the Social Security Act as they relate to denial of claims for home health services.

(e) MISCELLANEOUS PROVISIONS.—

(1) The Advisory Committee shall elect one of its members to serve as Chairman.

(2)(A) A majority of the members of the Advisory Committee shall constitute a quorum for the transaction of business.

(B) The Advisory Committee shall meet at the call of the Chairman, or at the call of a majority of its members.

(3) Members of the Advisory Committee shall serve without compensation, but shall be entitled to reimbusement for travel, subsistence, and other necessary expenses incurred in the performance of their duties as members of the Committee.

(4) The Advisory Committee may appoint and fix the compensation of such personnel as it deems advisable, in accordance with the provisions of title 5, United States Code, governing appointments to the competitive service, and the provisions of chapter 51 and subchapter III of chapter 53 of such title, relating to classification and General Schedule pay rates.

(5) In carrying out its duties, the Advisory Committee is authorized to hold such hearings, sit and act at such times and places, and take such testimony, with respect to matters for which is has a responsibilty under this section, as the Committee may deem advisable.

(6) The Advisory Committee may secure directly from any department or agency of the United States such data and information as may be necessary to carry out its responsibilities. Upon request of the Committee, any such department or agency shall furnish any such data or information.

(7) The General Services Administration shall provide to the Commission, on a reimbursable basis, such administrative support services as the Advisory Committee may request.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 428. PROHIBITION OF MISUSE OF SYMBOLS, EMBLEMS, OR NAMES IN REFERENCE TO SOCIAL SECURITY OR MEDICARE.

(a) IN GENERAL.—Part A of title XI is amended by adding at the end the following new section:

"PROHIBITION OF MISUSE OF SYMBOLS, EMBLEMS, OR NAMES IN REFERENCE TO SOCIAL SECURITY OR MEDICARE

"SEC. 1140. (a) No person may use, in connection with any item constituting an advertisement, solicitation, circular, book, pamphlet, or other communication, or a play, motion picture, broadcast, telecast, or other production, alone or with other words, letters, symbols, or emblems—

"(1) the words 'Social Security', 'Social Security Account', 'Social Security System', 'Social Security Administration', 'Medicare', 'Health Care Financing Administration', the letters 'SSA' or 'HCFA', or any other combination or variation of such words or letters, or

"(2) a symbol or emblem of the Social Security Administration (including the design of, or a reasonable facsimile of the design of, the social security card issued pursuant to section 205(c)(2)(E), the check used for payment of benefits under title II, or envelopes or other stationery used by the Social Security Administration) or of the Health Care Financing Administration, or any other combination or variation of such symbols or emblems,

in a manner which such person knows or should know would convey the false impression that such item is approved, endorsed, or authorized by the Social Security Administration, the Health Care Financing Administration, or the Department of Health and Human Services or that such person has some connection with, or authorization from, the Social Security Administration, the Health Care Financing Administration, or the Department of Health and Human Services.

"(b)(1) Subject to paragraph (2), the Secretary may, pursuant to regulations, impose a civil money penalty not to exceed—

"(A) except as provided in subparagraph (B), $5,000, or

"(B) in the case of a violation consisting of a broadcast or telecast, $25,000,

against any person for each violation by such person of subsection (a).

"(2) The total amount of penalties which may be imposed under paragraph (1) with respect to multiple violations in any one year period consisting of substantially identical communications or productions shall not exceed $100,000.

"(c)(1) Subsections (c), (d), (e), (g), (j), and (k) of section 1128A shall apply with respect to violations under subsection (a) and penalties imposed under subsection (b) in the same manner and to the same extent as such subsections apply with respect to claims in violation of section 1128A and penalties imposed under section 1128A(a).

"(2) Penalties imposed against a person under subsection (b) may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in the district court of the United States for the district in which the violation occurred or where the person resides, has its principal office, or may be found, as determined by the Secretary. Amounts recovered under this section shall be paid to the Secretary and shall be deposited as miscellaneous receipts of the Treasury of the United States. The amount of such penalty when finally determined, or the amount

agreed upon in compromise, may be deducted from any sum then or later owing by the United States to the person against whom the penalty has been imposed.".

(b) AUTHORIZING CIVIL MONEY PENALTIES FOR CERTAIN VIOLATIONS RELATING TO MEDICAL SUPPLEMENTAL POLICIES.—Section 1882(d) (42 U.S.C. 1395ss(d)) is amended—

(1) by striking "shall be guilty" and all that follows through "or both" in each of paragraphs (1), (2), (3)(A), and (4)(A), and inserting in each case the following: "shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act", and

(2) by adding at the end the following new paragraph:

"(5) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under paragraphs (1), (2), (3)(A), and (4)(A) in the same manner as such provisions apply to penalties and proceedings under section 1128A(a).".

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply only with respect to violations occurring on or after such date.

SEC. 429. DEMONSTRATION PROJECTS WITH RESPECT TO CHRONIC VENTILATOR-DEPENDENT UNITS IN HOSPITALS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall provide for up to 5 demonstration projects, for up to 3 years each, to review the appropriateness of classifying chronic ventilator-dependent units in hospitals as rehabilitation units. Such projects shall be conducted in consultation with the Prospective Payment Assessment Commission.

(b) WAIVER AUTHORITY.—In conducting demonstration projects under this section for units, the Secretary may treat such a unit as a rehabilitation unit described in section 1886(d)(1)(B) of the Social Security Act for purposes of such section.

And the Senate agree to the same.

From the Committee on Ways and Means, for consideration of titles I, II, and IV of the House bill, and the entire Senate amendment (except for secs. 14, 14A, 14B, 14C, 19, 29, and 25), and modifications committed to conference:

DAN ROSTENKOWSKI,
PETE STARK,
BRIAN J. DONNELLY,
WILLIS D. GRADISON, JR.,

From the Committee on Energy and Commerce, for consideration of titles II, III, and IV of the House bill, and the Senate amendment (except for secs. 2, 3, 12, and 18(a)) and for sec. 6 of the Senate amendment insofar as consideration of such section entails changes in eligibility require-

ments to participate in part B of the Medicare program, and modifications committed to conference:

JOHN D. DINGELL,
HENRY A. WAXMAN,
RON WYDEN,
EDWARD R. MADIGAN
(except for sec. 204 of the House bill and sec. 7 of the Senate amendment),

For consideration of sec. 204 of the House bill and sec. 7 of the Senate amendment:

MICHAEL BILIRAKIS,

From the Committee on Education and Labor, for consideration of sec. 21 of the Senate amendment, and modifications committed to conference:

GUS HAWKINS,
WILLIAM CLAY,
JAMES JEFFORDS,
Managers on the part of the House.

LLOYD BENTSEN,
MAX BAUCUS,
BILL BRADLEY,
GEORGE MITCHELL,
DAVID PRYOR,
JOHN H. CHAFEE,
JOHN HEINZ,
DAVID DURENBERGER,
Managers on the part of the Senate.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2470) to amend title XVIII of the Social Security Act to provide protection against catastrophic medical expenses under the medicare program, and for other purposes, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The Senate amendment struck out all of the House bill after the enacting clause and inserted a substitute text.

The House recedes from its disagreement to the amendment of the Senate with an amendment which is a substitute for the House bill and the Senate amendment. The differences between the House bill, the Senate amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clarifying changes.

1. Short Title; References in Act; Table of Contents (Section 1 of House bill; Section 1 of Senate amendment)

Present law

No provision.

House bill

Specifies that the act may be cited as the "Medicare Catastrophic Protection Act of 1987." Specifies that, except as otherwise specifically provided, whenever an amendment in this act is stated as an amendment or repeal of a section or provision, the reference is to the Social Security Act. Includes a table of contents.

Senate amendment

Similar provision, except specifies that act may be cited as the "Medicare Catastrophic Loss Prevention Act of 1987."

Conference agreement

The conference agreement specifies that the Act may be cited as the Medicare Catastrophic Coverage Act of 1988.

2. Inpatient Hospital Services (Section 101 of House bill; Sections 2 and 3 of Senate amendment)

Present law

(a) Deductible/Spell of Illness.—During each "spell of illness", beneficiaries are required to pay an inpatient hospital deductible ($540 in 1988). A spell of illness is defined as beginning when a beneficiary enters a hospital and ending when he or she has not been in a hospital or skilled nursing facility for 60 days.

(b) Limitation on Covered Inpatient Days.—(1) A beneficiary is entitled to 90 days of inpatient hospital services during each spell of illness. An additional lifetime reserve of 60 days may be drawn upon when an individual exceeds 90 days in a spell of illness. Medicare payment ceases after a beneficiary has used 90 days in a benefit period and exhausted the lifetime reserve days.

(2) The program includes an inpatient psychiatric carryover restriction for persons who are inpatients of a psychiatric hospital on the first day of Medicare entitlement. Days during the immediately preceding 150 days that the individual is an inpatient of a psychiatric hospital are subtracted from the 150 days that would otherwise be available in the initial spell of illness for inpatient psychiatric services.

(c) Coinsurance.—Beneficiaries are liable for daily coinsurance charges, equal to one-quarter of the inpatient hospital deductible for days 61–90 in a spell of illness ($135 in 1988). In addition, beneficiaries are liable for daily coinsurance charges, equal to one-half of the inpatient hospital deductible, for the 60 lifetime reserve days ($270 in 1988).

(d) Part A Premium.—Individuals aged 65 or over who are not automatically entitled to Part A may voluntarily enroll in the program if they pay a monthly premium. The premium amount, updated annually for the following year, is equal to $33 multiplied by the ratio of the inpatient hospital deductible for the following year to the inpatient hospital deductible in 1973.

(e) Adjustment in PPS Payment Rates.—Annual adjustments are made in payment amounts to PPS and PPS-exempt hospitals. Beginning in fiscal year 1988, the Secretary is required to adjust annually hospital weighting factors. Adjustments to outlier cutoff points are made periodically.

House bill

(a) Deductible/Spell of Illness.—Specifies that the deductible is to be applied to the first period of continuous hospitalization that begins in a calendar year. A beneficiary is required to pay only one deductible in a calendar year.

Eliminates "spell of illness" concept.

Specifies that beneficiaries whose "spell of illness" (for which a deductible is imposed) began before January 1, 1988, and had not yet ended as of such date, would not be required to pay an additional deductible for that spell of illness in 1988 or 1989.

(b) Limitation on Covered Inpatient Days.—

(1) Repeals limitations on number of covered inpatient days.

(2) Specifies that the psychiatric carryover restriction applies for the period beginning on the first day of Medicare entitle-

ment and ending at the end of the first period of 60 consecutive days on which the individual is not receiving inpatient psychiatric hospital services. The 150-day limitation is retained.

(c) Coinsurance.—Repeals coinsurance requirements, including, those required for emergency hospital services provided by a hospital that does not participate in Medicare.

(d) Part A Premium.—Requires the Secretary in September of each year (beginning in 1987), to establish the Part A monthly premium amount for the following year equal to the estimated actuarial value of the Part A benefit for such year (rounded to the nearest dollar). The actuarial value equals one-twelfth of the estimated average per capita amount payable from the Federal Hospital Insurance Trust Fund for services and related administrative costs incurred with respect to persons aged 65 and over for Part A benefits for the entire year. The Secretary is required, when the premium amount is promulgated, to issue a public statement setting forth the actuarial assumptions and bases employed in arriving at an adequate actuarial rate.

(e) Adjustment in PPS Payment Rates.—Requires the Secretary (when adjusting payment rates for PPS and non-PPS hospitals, the target amounts, the weighting factors, and the outlier cutoff points), when appropriate, to take into account reductions in beneficiary payments to hospitals resulting from the repeal of the day limitation on inpatient hospital services.

Effective date.—(a) Applies to the deductible for 1988 and succeeding years. (b) and (c) apply to inpatient hospital services furnished on or after January 1, 1988. (d) Applies to premiums for months beginning with January 1, 1988. Conforming amendments effective January 1, 1988. (e) Effective on enactment.

Senate amendment

(a) Deductible/Spell of Illness.—Similar provision, except limited to persons covered under both Part A and Part B. The deductible applies to the first "period of hospitalization" beginning in a calendar year. "Period of hospitalization" is defined as beginning on the first day the individual is furnished inpatient hospital services and ending on the date of discharge from the hospital (or, in the case of a transfer, hospitals) involved.

Eliminates "spell of illness" for persons covered under both Parts A and B.

Specifies that beneficiaries whose period of hospitalization (for which a deductible is imposed) begins during December of a calendar year would not be required to pay an additional deductible for a hospitalization beginning in January of the following year.

(b) Limitation on Covered Inpatient Days.—

(1) Similar provision, except limited to persons covered under both Parts A and B.

(2) Repeals psychiatric carryover restriction for persons covered under both Parts A and B.

(c) Coinsurance.—Similar provision, except limited to persons covered under both Parts A and B. Coinsurance requirements for services furnished outside the United States are also eliminated for these persons.

(d) Part A Premium.—No provision.

(e) Adjustment in PPS Payment Rates.—No provision.

Effective date.—Applies to items and services furnished after December 31, 1987, Beneficiaries (covered under both Parts A and B) whose spell of illness begins before January 1, 1988 and whose period of hospitalization included in that spell of illness begins on or after January 1, 1988 and before February 1, 1988 would not have an inpatient hospital deductible imposed for that period of hospitalization.

(a) *Deductible/Spell of Illness.*—The conference agreement includes the House provision with an amendment. The agreement provides that a beneficiary, whose period of hospitalization (for which a deductible is imposed) begins during December of a calendar year, would not be required to pay an additional deductible for a hospitalization beginning in January of the following year.

The agreement provides that, if the Secretary terminates a contract with a health maintenance organization (HMO) or competitive medical plan (CMP) during a year, no inpatient hospital deductible will be imposed for the remainder of the year on a beneficiary who can demonstrate that he or she, while enrolled in the organization during the year, had an inpatient hospital admission paid for by the HMO or CMP.

(b) *Limitation on Covered Inpatient Days.*—The conference agreement includes the House provision.

(c) *Coinsurance.*—The conference agreement includes the Senate amendment with an amendment deleting the requirement that individuals be enrolled in both Parts A and B.

(d) *Part A Premium.*—The conference agreement includes the House provision with an amendment specifying that the Secretary is first required to establish the monthly premium in September of 1988 which will be in effect for calendar year 1989.

(e) *Adjustment in PPS Payment Rates.*—The conference agreement includes the House provision with an amendment. Under the agreement, the Secretary shall adjust the target amounts for each non-PPS hospital to reflect reductions in beneficiary payments to hospitals resulting from the enactment of this legislation.

(f) *Chronic Ventilator-Dependent Units in Hospitals.*—The conference agreement includes a provision requiring the Secretary to establish up to five demonstration projects for up to three years each to review the appropriateness of classifying chronic ventilator-dependent units in hospitals as rehabilitation units. The Secretary is authorized to treat such units as rehabilitation units for reimbursement purposes.

The conferees expect that the Secretary will establish criteria for the demonstration projects which will assure that (1) the units will serve patients who have recently undergone tracheostomy and are newly ventilator-dependent; (2) there is reasonable expectation at admission that the patient will be able to return home or to the community at discharge; (3) the major diagnoses of patients will include spinal cord injury, head trauma, advanced lung disease, Guillain-Barre syndrome, musuclar dystrophy—Duchenne type, polyomyositis and dermatomyositis, and phrenic nerve paralysis secondary to surgical trauma; (4) the rehabilitation programs within the units will include physcial therapy, patient and family instruction

in the use of ventilator equipment, self-suctioning and medications, and psychological counseling; (5) expected length of stay within the units will be typically two to four months; and (6) other factors which the Secretary finds relevant.

In establishing the demonstrations the Secretary is required to consult with the Prospective Payment Assessment Commission. In addition, the conferees expect that the Secretary will consult with appropriate professional groups such as the American Thoracic Society and the American College of Chest Physicians.

Effective date.—The Conference agreement applies to the deductible for 1989 and succeeding years. Other provisions apply to care and services occurring on or after January 1, 1989, except that (d) is effective and applies to premiums for January 1989 and succeeding months and (e) is effective for PPS hospital discharges on or after January 1, 1989, and for non-PPS hospitals, for cost reporting periods beginning on or after October 1, 1989.

3. Extended Care Service (Section 102 of House bill; Sections 2 and 3 of Senate amendment)

Present law

(a) Coinsurance.—Beneficiaries are required to pay a daily coinsurance charge (equal to one-eighth of the inpatient hospital deductible) for days 21–100 of post-hospital extended care services furnished during each spell of illness.

(b) Limitation on Covered Days.—The program covers up to 100 days of post-hospital extended care services in a spell of illness.

(c) Prior Hospitalization Requirement.—In order to have payment made for extended care services, the beneficiary must have been an inpatient of a hospital for at least three consecutive calendar days and have been transferred to a participating SNF usually within 30 days. The law has authorized the Secretary to provide coverage for extended care services in a SNF without regard to the 3-day prior hospitalization requirement when he determines that such coverage will not lead to an increase in cost and will not alter the acute nature of the benefit; however, this provision has not been implemented.

House bill

(a) Coinsurance.—

(1) Eliminates current coinsurance requirements. Imposes a daily coinsurance charge for days 1–7 of post-hospital extended care services furnished in a calendar year.

(2) Requires the Secretary, before September 1 of each year (beginning in 1987), to estimate the national average per diem reasonable cost recognized under Part A for post-hospital extended care services which will be furnished in the succeeding calendar year. In September of each calendar year (beginning in 1987) the Secretary is required to promulgate the coinsurance amount for the following year. The amount equals 20 percent (rounded to the nearest $0.50) of the national average per diem reasonable cost estimated by the Secretary. The reference to "post-hospital" is deleted beginning January 1, 1989.

(b) Limitation on Covered Days.—Provides coverage for 150 days of extended care services in a calendar year.

(c) Prior Hospitalization Requirement.—Eliminates prior hospitalization requirement and reference to authority to provide coverage without regard to this requirement.

(d) Spell of Illness.—Repeals spell of illness concept.

Effective date.—Applies to extended care services furnished on or after January 1, 1988, except that elimination of prior hospitalization requirements (and related conforming changes) apply to extended care services furnished pursuant to an admission to a SNF occurring on or after January 1, 1989.

Senate amendment

(a) Coinsurance.—

(1) Similar provision, except limited to persons covered under both Parts A and B. The daily coinsurance charge is imposed on the first 10 days the beneficiary is furnished extended care services during any stay in a skilled nursing facility (SNF), but in no event can a coinsurance amount be imposed for more than 10 days in a calendar year.

(2) Similar provision, except coinsurance equals 15 percent (rounded to the nearest $1.00) of the estimated amount. Eliminates reference to "post-hospital".

(b) Limitation on Covered Days.—Similar provision, except limited to persons covered under both Part A and Part B.

(c) Prior Hospitalization Requirement.—Similar provisions, except limited to persons covered under both Parts A and B.

(d) Spell of Illness.—Similar provisions, except limited to persons covered under Parts A and B.

Effective date.—Applies to extended care services furnished after December 31, 1987. For beneficiaries receiving post-hospital extended care services on December 31, 1987, current law provisions will continue to apply until the spell of illness has ended.

Conference agreement

(a) *Coinsurance.*—The conference agreement includes the House provisions with a modification. The agreement provides that coinsurance charges are to be imposed on the first eight days of extended care services in a calendar year. The amount of the coinsurance is equal to 20% (rounded to the nearest $0.50) of the estimated national average per diem reasonable cost recognized under Part A of Medicare for extended care services.

The agreement extends the current coverage of extended care services in a Christian Science sanatoria from a maximum of 30 days per benefit period to 45 days per calendar year. As under current law, coinsurance would be applied for each day of covered care.

(b) *Limitation on Covered Days.*—The conference agreement includes the Senate amendment with an amendment deleting the requirement that individuals be enrolled in both Parts A and B.

(c) *Prior Hospitalization Requirement.*—The conference agreement includes the House provision.

(d) *Spell of Illness.*—The conference agreement includes the Senate amendment with amendments. The requirement that indi-

viduals be enrolled in both Parts A and B is deleted. Beneficiaries whose "spell of illness" began before January 1, 1989, and had not yet ended as of such date, would not be required to pay an additional hospital deductible for that spell of illness in 1989 and 1990.

Effective date.—The conference agreement applies to extended care services furnished on or after January 1, 1989.

4. Hospice Care (Section 103 of House bill; Section 12 of Senate amendment)

Present law

A beneficiary who is terminally ill may elect to receive hospice services for two 90-day periods and one subsequent 30-day period for a total of 210 days during his lifetime. Beneficiaries making this election must choose to receive services through a hospice and give up most other Medicare benefits.

House bill

Provides for a subsequent extension period beyond the current 210-day limit, if the beneficiary is recertified as terminally ill by the medical director or the physician member of the interdisciplinary group of the hospice program.

Effective date.—Applies to hospice care furnished on or after January 1, 1988.

Senate amendment

Similar provision.

Effective date.—Applies with respect to services furnished on or after date of enactment.

Conference agreement

The conference agreement includes the House provision with an amendment to further extend the favorable presumption under the waiver of liability provision for hospice care through October 1990.

Effective date.—The conference agreement applies to hospice care furnished on or after January 1, 1989.

5. Blood Deductible (Section 104 of House bill; Section 3 of Senate amendment)

Present law

Payment may not be made under Part A for the first 3 pints of whole blood (or equivalent quantities of packed red blood cells, as defined in regulations) furnished to a beneficiary during a spell of illness. A similar deductible is applied under Part B on a calendar year basis. Under Part B, the deductible (in accordance with regulations) is appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells). For these purposes, blood furnished to an individual is deemed to be replaced when the institution or other person furnishing blood is given one pint of blood for each pint of blood furnished such individual for which the deductible is applicable.

The Part A and Part B blood deductibles are applied separately.

House bill

Specifies that the Part A blood deductible is applied on a calendar year basis. Replacement provisions (identical to those specified for Part (B) are added to Part A. The Part A blood deductible is to be reduced by any blood deductible imposed with respect to Part B.

Specifies that in the case of a beneficiary whose spell of illness begins before January 1, 1988 (and ends after that date), any Part A blood deductible required would be reduced during that spell of illness (during 1988 or 1989) to the extent that a Part A blood deductible had already been imposed for that spell of illness.

Effective date.—Applies to blood or blood cells furnished on or after January 1, 1988.

Senate amendment

Specifies that the Part A blood deductible is to be applied on a calendar year basis for persons covered under both Parts A and B.

Effective date.--Applies to items and services finished after December 31, 1987.

Conference agreement

The conference agreement includes the House provision.

Effective date.—The conference agreement applies to blood or blood cells furnished on or after January 1, 1989.

6. Home Health Benefits (Section 105 of House bill)

Present law

Home health services are covered under Parts A and B. Payments for home health services are always made under Part A except in cases where the beneficiary is enrolled under Part B, but is not entitled to Part A. In these cases, payment is made under Part B.

House bill

Provides that payments for home health services are to be made under Part A only in cases where the individual provided the services is not entitled to Part B in that month. Otherwise, payments are to be made under Part B.

Effective date.—Applies to home health services furnished on or after January 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision.

7. Imposition of Supplemental Medicare Premium (Section 106 of House bill; Sections 6 and 27 of Senate amendment)

Present law

(a) and (b) In General and Applicability.—The following individuals are eligible for coverage under the Hospital Insurance (Part A) program of Medicare without payment of any premium: (1) those

who have attained age 65 and are eligible for monthly Social Security retirement or survivor benefits, (2) individuals of any age who have been entitled for not less than 24 months to Social Security or Railroad Retirement benefits on the basis of disability (and certain related individuals), (3) individuals of any age who have end-stage renal disease, and (4) certain Federal, State, and local Government employees who have attained age 65. Individuals age 65 or over who are not entitled to Part A benefits because they do not meet the above conditions may enroll in Part A if they pay a monthly premium.

All individuals age 65 and older may elect to enroll in the Supplementary Medical Insurance (Part B) program of Medicare by paying a monthly premium, which is $24.80 in 1988. Individuals who have not attained age 65 but who are eligible for the Part A program by virtue of disability or end-stage renal disease may also elect to enroll in Part B by paying the monthly premium.

(c) Premium Amount.—No provision.

(d) Calculation for Governmental Retirees.—Currently, the pensions of most government retirees are, for the most part, treated as income subject to taxation, while Social Security benefits are tax-exempt unless they exceed a certain threshold (i.e., if adjusted gross income plus 50 percent of the Social Security benefit exceeds $25,000 for individuals, or $32,000 for married couples filing joint returns). These differences in tax treatment of pension income result in larger adjusted gross incomes and tax liabilities for government retirees than for retirees with Social Security.

(e) Premium Indexing.—No provision.

(f) Maximum Supplemental Premium.—No provision.

(g) Joint Returns.—Provides rules for the filing of joint returns for married individuals under section 6013 of the Internal Revenue Code of 1986.

(h) Coordination with Tax Code Provisions.—Section 213 of the Internal Revenue Code of 1986 provides that expenses for medical care (including prescribed drugs or insulin), not compensated for by insurance or otherwise, may be deducted for Federal income tax purposes to the extent that they exceed 7.5 percent of adjusted gross income. Medical care includes insurance payments and Medicare Part B premiums.

House bill

(a) In General.—Amends the Internal Revenue Code of 1986 to impose an annual income-related supplemental premium on Medicare-eligible individuals (generally, those entitled to Part A who file a Federal tax return, except (1) individuals required to pay a premium for Part A coverage, (2) residents of U.S. possessions, and (3) qualified nonresidents) for each taxable year.

(b) Applicability.—Defines a "Medicare-eligible individual" who is liable for payment of the supplemental Medicare premium as an individual who, in any month, is entitled to (or, on application without the payment of an additional premium, would be entitled to) benefits under Part A of Medicare for such month. Provides for the following exceptions: (1) individuals entitled to Part A benefits solely by reason of the payment of the Part A premium, (2) residents of U.S. commonwealths and territories who pay a special

Part B premium and individuals who are enrolled under Part B but are not entitled to benefits under Part A, and (3) qualified nonresidents.

Defines a "qualified nonresident" as an individual who: (1) is not furnished any service for which payment was or will be made under Medicare Part A during the taxable year or any of the 4 preceding taxable years, (2) is not entitled to benefits under Medicare Part B at any time during the taxable year or any of the 4 preceding taxable years, and (3) is present in a foreign country or countries for at least 330 full days during the 12-month period ending at the close of the taxable year and each of the 4 consecutive preceding 12-month periods. An individual who dies during the taxable year is treated as meeting the 330-day test in that year if the individual spent at least 90 percent of the days before the date of death as full days in a foreign country or countries.

Provides that an individual (other than a nonresident alien) who has attained age 65 will be treated as a Medicare-eligible individual for the month in which he attains age 65 and any subsequent month unless he establishes to the satisfaction of the Secretary that he is not a Medicare-eligible individual for the month concerned.

(c) Premium Amount.—

Provides that for 1988, the premium is as follows:

If the adjusted gross income for the taxable year is:		The annual premium for the taxable year is:
Over:	But not over:	
$0	$6,000	$0
6,000	6,143	10
6,143	6,287	20
6,287	6,430	30
6,430	6,573	40
6,573	6,716	50
6,716	6,860	60
6,860	7,003	70
7,003	7,146	80
7,146	7,289	90
7,289	7,433	100
7,433	7,576	110
7,576	7,719	120
7,719	7,862	130
7,862	8,006	140
8,006	8,149	150
8,149	8,292	160
8,292	8,436	170
8,436	8,579	180
8,579	8,722	190
8,722	8,865	200
8,865	9,009	210
9,009	9,152	220
9,152	9,295	230
9,295	9,438	240
9,438	9,582	250
9,582	9,725	260
9,725	9,868	270
9,868	10,011	280
10,011	10,155	290
10,155	10,298	300
10,298	10,441	310

If the adjusted gross income for the taxable year is: Over:	But not over:	The annual premium for the taxable year is:
10,441	10,585	320
10,585	10,728	330
10,728	10,871	340
10,871	11,014	350
11,014	11,158	360
11,158	11,301	370
11,301	11,444	380
11,444	11,587	390
11,587	11,731	400
11,731	11,874	410
11,874	12,017	420
12,017	12,160	430
12,160	12,304	440
12,304	12,447	450
12,447	12,590	460
12,590	12,734	470
12,734	12,877	480
12,877	13,020	490
13,020	13,163	500
13,163	13,307	510
13,307	13,450	520
13,450	13,593	530
13,593	13,736	540
13,736	13,880	550
13,880	14,023	560
14,023	14,166	570
14,166		580

Provides that if an individual is not a Medicare-eligible individual for each month during the taxable year, the annual premium determined from the above table would be prorated based on the number of months an individual is a Medicare-eligible individual during the taxable year. A similar rule applies in the case of a taxable year of less than 12 months, except that the individual's adjusted gross income for the taxable year would be annualized.

(d) Calculation for Governmental Retirees.—No provision.

(e) Premium Indexing.—

(1) In General.—Requires the Secretary of the Treasury, not later than December 15 of 1988 and each subsequent calendar year, to prescribe a table of the supplemental premium amounts which will apply, instead of the 1988 table, with respect to taxable years beginning in the succeeding calendar year.

Requires that each premium dollar amount in the 1988 table be increased by the sum of the Medicare inflation factor and the prescription drug factor for the calendar year, and each other dollar amount in the table (i.e., the bracket amount and the threshold amount) be increased by the cost-of-living adjustment used to index the income tax brackets. If any increase is not a mulitple of $1, it is to be rounded to the nearest multiple of $1.

(2) Catastrophic Coverage Benefit.—Provides that the Medicare inflation factor is the percentage (if any) by which the Medicare value for a calendar year exceeds the Medicare value

for 1988. The Medicare value for any calendar year is the sum for January of such year of (a) 50 percent of the monthly actuarial rate promulgated under section 1818(d)(1) of the Social Security Act for such month (i.e., the Medicare Part A value), and (b) the excess of twice the monthly Part B actuarial rate under section 1839(a)(1) of the Social Security Act, over the amount of the monthly Part B premium under section 1839 (i.e., the Medicare Part B value).

(3) Prescription Drug Benefit.—Provides that the prescription drug factor for 1988 is zero percent, for 1989 is 5.5 percent, and subsequent years is determined as follows: The Secretary of the Treasury in September of each year (beginning with 1989) is required to determine a percent estimated to be necessary so that the total amount of supplemental premiums attributable to the prescription drug factor estimated to be collectible in the next year is equal to 25 percent of the total of the benefits and related administrative costs estimated by the Secretary of HHS under new section 1839(g)(2)(C) of the Social Security Act to be necessary to pay for covered outpatient drugs in the next year.

Requires the Secretary of the Treasury in September of each year (beginning with 1991) to determine whether the amount of the supplemental premium attributable to the prescription drug factor estimated to be collectible (for taxable years beginning in calendar years after 1988 and before the previous calendar year) is greater or less than 25 percent of the total benefits and administrative costs paid for covered outpatent drugs.

If there is a surplus or deficit, the Secretary of the Treasury is required to adjust the prescription drug factor so as to reduce or increase, respectively, the aggregate amount of the additional premiums which are estimated to be collected by the amount of the surplus or deficit, taking into account the effect of any previous adjustments.

Provides that, notwithstanding the adjustment described above, the prescription drug factor for a year after 1990 cannot exceed 120 percent of such factor for the previous year.

(f) Maximum Supplemental Premium.—Provides that the maximum supplemental premium in 1988 is $580. The Joint Committee on Taxation estimates that the maximum supplemental premium in future years would be: for the taxable year beginning in 1989, $737; in 1990, $842; in 1991, $934; and in 1992, $1,017.

(g) Joint Returns.—Provides that in the case of a joint return, the premium amounts according to the table are applied separately to each spouse, and the adjusted gross income of each spouse is one-half of their combined adjusted gross income.

(h) Coordination with Tax Code Provisions.—

(1) Medical Expense Deduction.—Provides that the supplemental premium cannot be treated as a medical expense for purposes of section 213 of the Internal Revenue Code of 1986.

(2) Not Treated as a Tax for Certain Purposes.—Provides that the supplemental premium is not treated as a tax imposed by chapter 1 (income taxes) of the Internal Revenue Code of 1986 for purposes of determining the amount of any credit allowed

under that chapter or the amount of the alternative minimum tax imposed by section 55.

(3) Treated as a Tax for Subtitle F.— Provides that the supplemental premium is treated as if it were an income tax for administrative purposes, such as estimated payments and collection.

(4) Section 15 Not to Apply.—Provides that section 15 (procedures for applying changes in tax rates) does not apply to the supplemental premium.

(i) Reporting Requirements.—Requires the Secretary of HHS to make a return to the Secretary of the Treasury (at such time and in such form as determined by the Secretary of the Treasury) stating the name, address, and taxpayer identification number of each individual entitled to Medicare Part A benefits for any month during the calendar year and the number of months so entitled. The provision does not apply with respect to those who pay a premium under section 1818 for Part A coverage, residents of U.S. commonwealths and territories paying a special Part B premium, and individuals enrolled under Part B but not entitled to benefits under Part A.

(j) Transfer to Trust Funds.—No provision.

Effective date.—Applies to taxable years beginning after December 31, 1987.

Senate amendment

(a) In General.—Amends the Social Security Act to require individuals covered by Medicare Part B to pay an annual income-related supplemental premium if their Federal tax liability for taxable years is not less than $150.

(b) Applicability.—Provides that any individual who is covered by Medicare Part B for any portion of any taxable year occurring after December 31, 1987, and who has Federal income tax liability for such taxable year in an amount not less than $150 must pay the applicable supplemental premium.

(c) Premium Amount.—Provides that the "applicable supplemental premium" equals the number of months in the taxable year during which the individual was covered by Part B, multiplied by the supplemental premium. The "supplemental premium" is defined as the premium rate for the taxable year ($1.09 for the 1988 taxable year), multipled by the amount determined by dividing the individual's adjusted Federal income tax liability for the taxable year by $150.

If the latter amount is not a whole number, it is to be rounded to the next lowest whole number.

(d) Calculation for Governmental Retirees.—For purposes of calculating the supplemental premium, defines "Federal income tax liability" as the tax imposed by chapter 1 (income tax) of the Internal Revenue Code of 1986, reduced by credits allowed under part IV of subchapter A, excluding the following refundable credits: Section 31 (wage withholding for income tax purposes); section 33 (tax withheld at source on nonresident aliens and foreign corporations); and section 34 (certain uses of gasoline and special fuels).

For purposes of calculating the supplemental premium, defines "adjusted Federal income tax liability" as an amount equal to Fed-

eral income tax liability, reduced by the following amount. The reduction is the excess (if any) of:

(1) 15 percent of the lesser of (a) the qualified Social Security exclusionary amount, or (b) the amount received as an annuity (whether for a period certain or during 1 or more lives) under a governmental plan which is includible in gross income under section 72 of the Internal Revenue Code of 1986, over

(2) the amount of credit allowed under the tax credit for the elderly and the permanently and totally disabled (section 22 of the Internal Revenue Code of 1986).

Defines "qualified Social Security exclusionary amount" as the excess (if any) of $6,000 ($9,000 in the case of married individuals filing a joint tax return) over the Social Security benefits (as defined in section 86(d) of the Internal Revenue Code of 1986) received during the taxable year. For taxable years beginning after Dec. 31, 1988, the $6,000 and $9,000 amounts are increased from the previous year's amounts by the Social Security cost-of-living adjustment for the calender year in which the taxable year begins.

(e) Premium Indexing.—

(1) In General.—Provides that the premium rate for any taxable year (beginning in a calendar year after 1988) is the previous year's rate, increased or decreased by (a) the premium rate adjustment used to index the monthly catastrophic coverage premium amount in years after 1988, and (b) the drug premium rate adjustment (for taxable years beginning in calendar years after 1989).

(2) Catastrophic Coverage Benefit.—The premium rate adjustment used to update the monthly catastrophic coverage premium amount is:

(a) the percentage (if any) necessary to increase the estimated total revenues collectable from the monthly catastrophic coverage premiums and the supplemental premiums (determined without regard to the drug premium rate adjustment amount) so that they equal the estimated total catastrophic coverage benefits and related administrative costs (including administrative costs for outpatient drug coverage), plus

(b) for calendar years before 1993, the percentage necessary to establish before 1993 a contingency fund equal to 20 percent or, if greater, a reserve fund equal to 5 percent.

(3) Prescription Drug Benefit.—Provides that the drug premium rate adjustment for taxable years beginning in a calendar year after 1989 is an amount equal to:

(a) 50 percent (60 percent for calendar year 1990 and 55 percent for calendar year 1991, as provided in Section 27 of the bill) of the modified per enrollee actuarial catastrophic drug benefit amount for that year plus

(b)(1) for any taxable year beginning in calendar year 1990, an amount necessary to cover 7.5 percent of the modified per enrollee actuarial catastrophic drug benefit amount for 1991, and

(2) for taxable years beginning in calendar years after 1990, an amount (when added to any unexpended amount determined for any preceding year) necessary to cover 7.5

percent of the modified per enrollee actuarial catastrophic drug benefit amount for the calendar year.

Defines "modified per enrollee actuarial catastrophic drug benefit amount" to mean (a) the total catastrophic drug coverage benefits and related administrative costs estimated to be paid in cash outlays from the Federal Catastrophic Drug Insurance Trust Fund divided by the total number of individuals estimated to be enrolled under Part B for the year, or (b) the reestimated per enrollee actuarial catastrophic drug benefit amount that reflects any adjustment the Secretary may make to the drug coverage benefit because the drug benefit premium amount was determined to exceed the premium limit for that year.

(f) Maximum Supplemental Premium.—Provides that the applicable supplemental premium for any individual cannot exceed the number of months in the taxable year the individual was covered by Part B divided by 12, multiplied by the appropriate amount, as follows: for the taxable year beginning in 1988, $800; in 1989, $850; in 1990, $900; in 1991, $950; and in 1992, $1,000.

For taxable years beginning in a calendar year after 1992, the applicable supplemental premium cannot exceed 65 percent of the product of the number of months in the taxable year the individual was covered by Part B, multiplied by the excess of:

(a) the sum of (1) 200 percent of the monthly actuarial basic rate for Part B enrollees age 65 and over (i.e., 200 percent of one-half of the benefit and administrative costs, including a contingency margin, payable for the aged from the Part B trust fund for Part B costs excluding the catastrophic coverage), plus (2) the monthly per enrollee actuarial comprehensive catastrophic benefit amount (i.e., the estimated monthly catastrophic coverage benefits and related administrative costs payable from the Federal Catastrophic Health Insurance Trust Fund divided by the estimated number of Part B enrollees) for the calendar year, over

(b) the sum of the basic and catastrophic monthly premiums for the year, determined without regard to current and new certain hold harmless provisions (which provide limits to any increases in the Part B and catastrophic premiums based on cost-of-living increases in Social Security benefits).

(g) Joint Returns.—Provides that for married individuals (as defined in section 7703 of the Internal Revenue Code of 1986), the supplemental premium is determined by treating such individuals as one individual if they: (1) file a joint return (under section 6013 of such Code) and (2) one or both of them are covered by Part B for any portion of the taxable year and have Federal income tax liability of not less than $150. The number of months of Part B coverage is determined according to the spouse covered for the longer period during the taxable year. When married individuals are treated as one individual in order to calculate the supplemental premium, the limit on such premium equals the sum of the limits computed separately for each spouse.

(h) Coordination With Tax Code Provisions.—

(1) Medical Expense Deduction.—Provides that the supplemental premium is treated as a premium paid under Medicare

Part B in the taxable year following the taxable year to which the premium relates for purposes of section 213(d)(1)(C) of the Internal Revenue Code of 1986.

(2) Not Treated as a Tax for Certain Purposes.—Similar provision.

(3) Treated as a Tax for Subtitle F.—Similar provision.

(4) Section 15 Not to Apply.—Similar provision.

(i) Reporting Requirements.—Requires that the Secretary of HHSA include on the current return to the Secretary of the Treasury relating to Social Security benefits, the number of months any individual is covered under Medicare Part B for the calendar year. Requires the Secretary of HHS to include on the statements sent to Social Security beneficiaries information on the name of the agency making the determination and the number of months of coverage under Medicare Part B.

(j) Transfer to Trust Funds.—Requires the Secretary of the Treasury, from time to time, to transfer from the general fund of the Treasury to the Federal Catastrophic Health Insurance Trust Fund amounts equal to the aggregate monthly supplemental premiums paid (excluding the drug premium rate adjustment), plus the amount the Secretary of the Treasury estimates Federal outlays are reduced under the Medicaid program because of the catastrophic provisions of this bill (after taking into account the provisions of Section 14 of the bill related to Medicaid savings and State requirements). Such transfers are to be appropriately adjusted to the extent that prior transfers were in excess of or less than amounts required to be transferred.

Also requires the Secretary of the Treasury, from time to time, to transfer from the general fund of the Treasury to the Federal Catastrophic Drug Insurance Trust Fund amounts equal to the aggregate drug premium rate adjustment paid, adjusted to the extent that prior transfers were in excess of less than the amounts required to be transferred.

Effective date.—Applies to taxable years ending after December 31, 1987. The supplemental premium rate for any taxable year beginning before 1988 and ending after December 31, 1987, is the rate applicable to 1987.

Conference agreement

(a) *In General.*—Under the conference agreement, medicare Part A eligible individuals are required to pay a new tax-related supplemental premium. The supplemental premium is intended to provide approximately 63 percent of catastrophic coverage and prescription drug benefit financing on a calendar year liability basis, with flat monthly premiums financing the remaining 37 percent (subject to limitations on increases and decreases in the supplemental premium, described below).

The supplemental premium is drafted in the tax Code, collected with income tax payments, and after 1989 subject to income tax estimated payments. Medicare Part A eligible individuals with less than $150 of income tax liability are exempt from the supplemental premium.

To reduce confusion among beneficiaries, the conferees intend that the Secretary of the Treasury is to (1) implement the supple-

mental premium in an easy to understand manner (including the use of premium tables in lieu of taxpayer calculations, and separate tables as necessary for government retirees), (2) identify the supplemental premium on the applicable forms, worksheets, tables, and instructions as a premium to pay for a portion of the cost of new medicare catastrophic and prescription drug coverage, and (3) seek comments and advice from medicare enrollees and their representatives regarding the design of such forms, worksheets, tables, and instructions.

(b) *Applicability.*—The definition of medicare Part A eligible individuals generally follows the House bill, except that no special proration rule is provided for residents of U.S. commonwealths and territories. Residents of U.S. commonwealths and territories who do not have U.S. income tax liability are not subject to the supplemental premium. An individual is liable for the supplemental premium if such individual is medicare Part A eligible for more than 6 full months during the taxable year and has $150 or more of adjusted U.S. source income tax liability.

Unlike the House bill, individuals who attain the age of 65 during the taxable year are not presumed to be medicare eligible for the purposes of paying the supplemental premium. The conferees intend that the Internal Revenue Service will inform taxpayers that they are liable for the supplemental premium if they are eligible for Part A of Medicare even if they have not actually enrolled.

(c) *Premium Amount.*—For taxable years beginning before 1994, the supplemental premium rate is the sum of the catastrophic coverage and prescription drug premium rates shown below:

SUPPLEMENTAL PREMUIM RATES, 1989–93

[Per $150 of adjusted Federal income tax liability]

	Catastrophic coverage premium rate	Prescription drug premium rate	Total supplemental premium rate
Year in which taxable year begins:			
1989	$22.50	$0	$22.50
1990	27.14	10.36	37.50
1991	30.17	8.83	39.00
1992	30.55	9.95	40.50
1993	29.55	12.45	42.00

The supplemental premium is to be determined under tables (similar to the income tax tables) prescribed by the Secretary of the Treasury which may provide income tax liability brackets of less than $150.

For purposes of computing the supplemental premium, adjusted Federal income tax liability is defined as under the Senate amendment.

The conferees have determined these premium rates to raise sufficient revenue with reference to the tax rates and other important features of the tax Code that determine the liability of the medicare Part A eligible population. The conferees intend that if tax rates or these features are changed in future legislation, the premium rates should be recalibrated.

(d) *Calculation for Government Retirees.*—The Conference agreement generally follows the Senate amendment with changes designed to conform the adjustment for government retirees with the computation of the credit for the elderly and disabled. For government retirees, tax liability is adjusted by subtracting 15 percent of the excess (if any) of (1) the lesser of (i) $6,000 ($9,000 in the case of a joint return where both spouses are medicare eligible for more than 6 full months, and $4,500 for married individuals filing separate returns), or (ii) government annuities includible in gross income during the taxable year, the lower quantity then reduced by social security benefits received during the taxable year; over (2) the credit for the elderly and disabled allowable for the taxable year. After 1989, the $4,500, $6,000 and $9,000 amounts are increased by social security cost-of-living adjustments ("COLAs") determined for calendar years after 1989, and rounded to the nearest multiple of $50.

In the case of a joint return where only one spouse is medicare eligible for more than 6 full months during the taxable year, only government annuities attributable to such spouse are taken into account for purposes of the adjustment for government retirees. In the case of a married individual filing a separate return, such individual shall be treated as receiving not less than half of the social security benefits received by both spouses.

(e) *Premium Indexing.*—(1) *In general.* The method of indexing the supplemental catastrophic coverage and prescription drug premiums was selected by the conferees (1) to assure that premium receipts will be sufficient to pay for all catastrophic coverage and prescription drug benefits (i.e., budget neutrality), and (2) to minimize the Treasury Secretary's discretion over the adjustment of supplemental premium rates.

The indexing formula minimizes discretion by using information on prior year program costs and receipts, rather than subjective projections, and by limiting the amount by which the supplemental premium can be increased in any year.

The indexing machanism seeks to assure budget neutrality by several means: (1) prescription drug outlays may only be made from a new Federal Catastrophic Drug Insurance Trust Fund which is entirely financed by monthly and supplemental prescription drug premiums (and interest on fund balances); (2) monthly and supplemental catastrophic coverage premiums are increased to recoup with interest shortfalls in prior years (monthly premiums are increased to make up for any limitation on the increase in the supplemental premium); and (3) a contingency margin of at lest 20 percent is built into catastrophic coverage and prescription drug premiums.

For taxable years beginning after 1993, the supplemental premium rate is the sum of the adjusted catastrophic coverage premium rate and the adjusted prescription drug premium rate, subject to two limitations. The supplemental premium rate may not (1) be less than the rate in effect for the preceding year; and (2) be more than $1.50 per $150 of tax liability higher than the rate in effect for the preceding year. If either of these two limitations are applicable, the supplemental premium rate is allocated between the catastrophic coverage and prescription drug premium rates in propor-

tion to the respective amounts of these premium rates without regard to the limitations.

(2) *Catastrophic coverage premium.*—The adjusted catastrophic coverage premium rate for any calendar year after 1993 is equal to the rate for the preceding calendar year, without regard to the two limitations on the supplemental premium described above in any prior year, adjusted by a percentage equal to the sum of the outlay-premium and reserve account percentages.

The outlay-premium percentage is designed to index the supplemental catastrophic coverage premium rate by the difference between the projected growth rates of catastrophic coverage outlays and premiums. For years after 1993, the growth in outlays and premiums is projected by a formula which uses data available for the second and third preceding years, plus more recent information on trends in the consumer price index.

The outlay-premium percentage for any calendar year is (1) the percentage change in per capita catastrophic outlays from the third to the second preceding calendar year; minus (2) the percentage change in per capita catastrophic coverage premium liability from the third to the second preceding calendar year (determined as if the supplemental premium rate had not changed from the third to the second preceding year).

The per capita catastrophic outlay for any calendar year, as determined by the Secretary of HHS, is equal to outlays debited from the Medicare Catastrophic Coverage Account (the "Account," see section 17, below) for such year, divided by the average number of individuals entitled to receive Part A benefits during such year.

The per capita catastrophic coverage premium liability for any calendar year, as determined by the Secretary of the Treasury, is equal to supplemental premium liability attributable to the catastrophic coverage premium for taxable years beginning in such year, divided by the number of individuals who had premium liability for taxable years beginning in such year.

The outlay-premium percentage, described above, is adjusted up (or down) by 50 percent of the amount by which the consumer price index ("CPI") inflation rate in the second preceding year exceeds (or is less than) one percentage point.

The CPI inflation rate for any year is defined as the percentage by which the CPI for May of such year exceeds such index for May of the preceding year. The CPI means the last CPI for all-urban consumers published by the Department of Labor, which is most consistent with the CPI for calendar year 1986.

The reserve account percentage is designed to adjust the supplemental catastrophic coverage premium rate to recoup 63 percent of any cumulative shortfall or deficit in the catastrophic coverage program (the other 37 percent is recouped by a corresponding adjustment in the flat premium). For years after 1993, the shortfall or surplus in the catastrophic coverage program is determined from data available for the second proceding year.

The reserve account percentage for any calendar year is the ratio of (1) the change in the catastrophic coverage premium rate for the second preceding year which the Secretary determines would have increased (or decreased) supplemental premium liability for such year by an amount equal to 63 percent of the shortfall (or surplus)

in the Account in such year, over (2) the catastrophic coverage premium rate for the preceding calendar year, without regard to the two limitations on the supplemental premium described above.

The shortfall (or surplus) in the Account for any calendar year is determined as (1) 20 percent of catastrophic outlays debited against the Account; minus (2) the Account balance at the end of such year (including flat and supplemental premium increase amounts attributable to reserve account percentages in prior years that have not yet been credited to the account.

(3) *Prescription Drug Premium.*—The adjusted prescription drug premium rate for any calendar year after 1993 is equal to the rate for the preceding calendar year, without regard to the two limitations, described above, which may have applied to the supplemental premium for any prior year, adjusted by a percentage determined in a manner similar to the catastrophic coverage premium, with the following changes: (1) in determining the premium-outlay percentage, prescription drug outlays rather than catastrophic outlays are used; (2) in determining the reserve account percentage, the Federal Catastrophic Drug Insurance Trust Fund balance (see section 16, below) is used rather than the Account balance; (3) the reserve account percentage is 75 percent for 1994, 50 percent for 1995, and 25 percent for 1996 and 1997, instead of 20 percent; and (4) the outlay-premium percentage is deemed to be zero for calendar years before 1998.

For calendar years after 1992 the following procedure is to be followed for announcing supplemental premium rate changes. The Secretary of the Treasury shall: (1) not later than July 1, announce the preliminary increase in the supplemental premium for the following year; and (2) not later than October 1, announce the actual supplemental premium rates for the following year. (For additional detail see sections 16 and 17, below).

(f) *Maximum Supplemental Premium.*—For taxable years beginning before 1994, the maximum supplemental premium for an individual filing a single return is $800 in 1989, $850 in 1990, $900 in 1991, $950 in 1992, and $1050 in 1993.

For calendar years after 1993, the maximum supplemental premium is equal to such maximum in the preceding year (before rounding) increased by the percentage (if any) by which the medicare-part B value for the second preceding year exceeds such value for the third preceding year. The maximum supplemental premium is rounded to the nearest multiple of $50. The conferees designed the formula to maintain the mixiumum supplemental premium as a constant fraction of the value of Part B benefits not paid for by monthly premiums.

The midicare-part B value for any calendar year is defined as the excess of per capita Part B outlays the year over 12 times the generally applicable monthly Part B premium for months in such calendar year. Per capita Part B outlays are outlays from Part B of title XVIII of the Social Security Act divided by the average number of individuals covered under such part during the year. In computing the maximum supplemental premium for years before 1988, the medicare-Part B value is computed by excluding outlays and monthly premiums for covered outpatient drugs.

(g) *Joint and Separate Returns.*—(1) *Joint returns.*—In the case of a joint return where both spouses are medicare Part A eligible for more than 6 full months during the taxable year, such spouses are treated as a single individual, except that the maximum supplemental premium is twice the amount that applies for single returns.

In the case of a joint return where only one spouse is medicare eligible for more than 6 full months during the taxable year, income tax liability for the medicare-eligible spouse is determined as one-half of the tax liability of the joint return.

(2) *Separate Returns.*—In the case of a married individual filing a separate return who did not live apart from his or her spouse at all times during the taxable year, such individual is treated as medicare Part A eligible for 6 full months during the taxable year if the individual or the individual's spouse was so eligible. In addition, the maximum supplemental premium is twice the amount that applies for single returns if, without regard to this provision, both spouses are Medicare Part A eligible for 6 full months during the taxable year.

These rules are intended to prevent the supplemental premium from creating an incentive for separate filing.

(h) *Coordination with Tax Code Provisions.*—(1) *Medical expense deduction.*—As under the House bill, the supplemental premium is not deductible as an itemized medical expense.

(2) *Not treated as a tax for certain purposes.*—As under the House bill and the Senate amendment, the supplemental premium is not treated as an income tax for purposes of determining the amount of any tax credit or the amount of the alternative minimum tax. Revenues from the supplemental premium are not covered over to any possession of the United States, and the supplemental premium is not automatically reflected in the tax laws of territories that "mirror" the U.S. tax Code. In the case of a taxable years of less than 12 months, the supplemental premium shall be applied under regulations prescribed by the Secretary.

(3) *Treated as a Tax for Subtitle F.*—The supplemental premium generally is treated as if it were an income tax for administrative purposes, such as estimated payment and collection. The conference agreement provides that estimated tax penalties do not apply with respect to supplemental premium liability for taxable years beginning in 1989. The conferees intend that the Internal Revenue Service will where appropriate exercise its discretion to provide relief from estimated tax penalties in the first year in which an individual becomes liable for the supplemental premium (similar relief already is provided for newly retired or disabled individuals in sec. 6654(e)(3)(B)).

(4) *Section 15 not to Apply.*—The supplemental premium is not treated as a change in income tax rate.

(i) *Reporting Requirements.*—The Secretary of HHS shall include in the existing return to the Secretary of the Treasury relating to social security benefits, a determination of whether any individual was medicare Part A eligible for more than 6 full months during the year. The Secretary of HHS is to include the same information on the statements sent to social security and railroad retirement

beneficiaries, as well as the name of the agency which determines medicare eligibility.

The Secretary of HHS may provide such additional information to the Secretary of the Treasury as is required to assure compliance with the supplemental premium.

(j) *Transfer to Trust Funds.*—Receipts attributable to the supplemental prescription drug premium rate are appropriated to the CDI trust fund. The Secretary of the Treasury is to transfer these appropriated amounts from the general fund to the CDI trust fund not less frequently than monthly, and at the close of the calendar year, determined on the basis of estimates; adjustments are made in subsequent transfers to take account of estimating errors. For individuals paying the maxmium supplemental premium, receipts are allocated between the supplemental prescription drug and catastrophic coverage premiums pro rata on the basis of the respective premium rates.

Receipts attributable to the supplemental catastrophic coverage premium rate, which are not otherwise appropriated to the Federal Hospital Insurance Catastrophic Coverage Reserve Fund (the "Reserve Fund") are appropriated to the SMI trust fund. The Secretary of the Treasury is to transfer these appropriated amounts from the general fund to the SMI trust fund not less frequently than monthly, and at the close of the calendar year, determined on the basis of estimates; adjustments are made in subsequent transfers to take account of estimating errors. For individuals paying the maximum supplemental premium, receipts are allocated between the supplemental prescription drug and catastrophic coverage premiums pro rata on the basis of the respective premium rates.

Effective date.—The supplemental premium is effective for taxable years beginning after December 31, 1988.

8. Delay in Organ Procurement Requirements (Section 26 of Senate amendment)

Present law

The Omnibus Budget Reconciliation Act of 1986 provided that Medicare payments for organ procurement would not be made unless: (a) the organ procurement agency involved met specified requirements and was designated by the Secretary as the sole procurement agency in its service area, and (b) hospitals establish protocols for making a routine inquiry for organ donation by potential donors, and are members of the National Organ Procurement and Transplantation Network.

Under the Omnibus Budget Reconciliation Act of 1986, these provisions were to be effective as of October 1, 1987. The Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987 changed this effective date to November 21, 1987. The Omnibus Budget Reconciliation Act of 1987 extends the effective date for item (a) to March 31, 1988.

House bill

No provision.

Senate amendment

Extends to December 31, 1988, the date by which the Secretary must complete the organ procurement agency designation process, the effective date of the requirements for hospital protocols for organ procurement, and the effective date for requiring hospitals to be members of the National Organ Procurement Network.

Effective date.—Enactment.

Conference agreement

The conference agreement does not include the Senate provision. The conferees note that a related provision was included in the Omnibus Budget Reconciliation Act of 1987.

9. Limitation on Medicare Out-of-Pocket Expenses (Section 201 of House bill; Sections 4 and 29 of Senate amendment)

Present law

Under current law, beneficiaries are liable for specified cost-sharing charges, in form of deductibles and coinsurance amounts, in connection with their use of inpatient hospital, skilled nursing facility, and hospice services, and blood under Part A.

Beneficiaries enrolling in Part B are required to pay a monthly premium. The program generally pays 80 percent of the reasonable charge for physicians and other covered medical services (including immunosuppressive drugs furnished within one year of a covered organ transplant) after the beneficiary has met the $75 deductible. The beneficiary is liable for the remaining 20 percent of the reasonable charge (coinsurance). In addition, where a physician does not accept assignment (i.e., does not agree to accept Medicare's determination of reasonable charge amount as payment in full for covered services), the beneficiary is liable for the difference between Medicare's reasonable charge and the physician's actual charge (the "balance billed amount"). The beneficiary is also liable for a separate Part B deductible.

There is no upper limit on the amount of cost-sharing charges beneficiaries are required to pay in connection with covered Medicare services.

House bill

(a) In General.—Establishes an annual limit on beneficiary out-of-pocket expenses (not including balance billed amounts) for covered part B services.

(b) Payment When Limit Has Been Reached.—Provides that if an individual has incurred out-of-pocket Part B expenses in a calendar year (beginning in 1989) equal to the Part B catastrophic limit for that year, the program will pay 100 percent of Part B reasonable charges (or costs) for covered Part B services (including physicians' services, ambulatory surgical center services, and dialysis services). In addition, after the beneficiary has reached the limit, no further blood deductible is required.

(c) Expenses Counting Toward the Catastrophic Limit.—Specifies that the following beneficiary expenses count toward the catastrophic limit:

(1) the Part B deductible, and blood deductible;
(2) Part B coinsurance charges; and
(3) a maximum of $250 in covered outpatient mental health expenses.

(d) Catastrophic Limit.—Specifies that the Part B catastrophic limit for 1989 is $1,043. The limit for any succeeding year is the limit for the preceding year increased by the Social Security cost-of-living adjustment (COLA), rounded to the nearest dollar. The Secretary is required to promulgate the Part B catastrophic limit by November 15 of each year (beginning with 1988) that will be in effect for the following year.

(e) Payments to Prepaid Health Plans Paid on a Reasonable Cost Basis.—Requires the Secretary to provide for an appropriate adjustment to payment rates for prepaid health plans paid on a reasonable cost basis to reflect the new catastrophic protection. The adjustment is to reflect: (1) the aggregate increase in payments which would otherwise be made for enrollees if they were not enrolled in the organization; or (2) the amount that would be paid to the organization or a facility if payments were made on an individual by individual basis. The organization is required to provide assurances, satisfactory to the Secretary, that it will not undertake to charge an individual during a year for covered services after the individual has reached the catastrophic limit (whether through the organization facility, or otherwise). [See Item 19(b)]

(f) Limitation on Charges When Catastrophic Limit Reached.—Specifies that providers (i.e., hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, or hospice programs) with agreements with the Medicare program may not charge beneficiaries for services for which catastrophic benefit payments are made to the provider.

(g) Notice for Beneficiaries Reaching Catastrophic Limit.—Requires Medicare carriers to provide individuals, who have incurred sufficient out-of-pocket expenses, to qualify for catastrophic benefits, with a notice in a form appropriate for presentation to a physician. The notice is to: (1) state that the individual has reached the Part B catastrophic limit for the year; and (2) encourage the physician not to charge the individual amounts in excess of Medicare's reasonable charge and to accept payment on an assignment related basis for the remainder of the year.

(h) No provision.

Effective date.—Enactment (applies to items and services furnished after December 31, 1988).

Senate amendment

(a) In General.—Establishes an annual limit on beneficiary out-of-pocket expenses (not including balance billed amounts) for covered Part A and B services and entitles a Part B beneficiary to have payment made to him or on his behalf for specific catastrophic medical expenses.

(b) Payment When Limit Has Been Reached.—Provides for payment of 100 percent of catastrophic medical expenses. "Catastrophic medical expenses" are defined with respect to an individual for a calendar year (beginning with 1988) as any beneficiary cost sharing amounts incurred by an individual after the individual has in-

curred specific out-of-pocket medical expenses equal to the catastrophic limit. The program will pay beneficiary cost sharing amounts for: (1) the hospital deductible, SNF coinsurance charges, hospice coinsurance charges, and the Part A blood deductible; (2) the Part B deductible and Part B blood deductible; and (3) Part B coinsurance charges.

(c) Expenses Counting Toward the Catastrophic Limit.—Specifies that the following beneficiary expenses count toward the catastrophic limit:

(1) the Part A hospital deductible, SNF coinsurance charges, hospice coinsurance charges, and blood deductible;

(2) the Part B deductible and blood deductible;

(3) Part B coinsurance charges;

(4) amounts expended for qualified services for the prevention of illness or injury. A service meets this definition if:

(A) The service is one of the following: glaucoma screening by tonometry, cholesterol screening, a "Pap" test for detecting breast cancer, an immunization or booster for tetanus, influenza, or bacterial pneumonia, an occult blood stool test, or tuberculosis sensitivity testing;

(B) The service has not been provided to the beneficiary in the preceding 12 months; and

(C) The service is provided incident to a comprehensive physical which is performed by a physician, which includes a full history and other specified components, and which meets such other requirements as the Secretary may prescribe, including requirements to ensure a comprehensive approach for preventive health services.

Requires the Secretary to establish guidelines for the described preventive services no later than January 1, 1989.

(d) Catastrophic Limit.—Specifies that the Medicare catastrophic limit is $1,850 for 1988 and $2,030 for 1989. The limit for any succeeding year is the limit for the preceding year increased by the percentage, as determined by the Secretary, which will ensure that the percentage of Part B eligibles (other than those enrolled in HMOs or CMPs) whose out-of-pocket costs are projected to exceed the limit during that year will be the same as the percentage whose costs exceeded the limit in 1989. The Secretary is required to promulgate the limit by November 15 of each year (beginning with 1987) that will be in effect for the following year.

(e) Payments to Prepaid Health Plans Paid on a Reasonable Cost Basis.—Similar provision. Adjustments in payment rates are also applicable for renal dialysis facilities. Assurances to the Secretary specify that the organization or facility will not charge the individual during a year for any catastrophic medical expense incurred during that year.

(f) Limitation on Charges When Catastrophic Limit is Reached.—Similar provision.

(g) Notice for Beneficiaries Reaching Catastrophic Limit.—No provision.

(h) Beneficiary Costs of Catastrophic Insurance.—

(1) Findings.—States that the Senate finds that: (A) Medicare catastrophic insurance will provide beneficiaries with important and far-reaching protection, greatly reducing out-of-pocket

liability for those who incur high medical expenses; (B) the new benefits will be financed through premiums collected from all beneficiaries; (C) the Department has announced that the Part B premium will increase by 38.5 percent in January, 1988; (D) Medicare beneficiaries already are liable for Medicare premiums equal to 2.9 percent of their median income; and (E) it is the responsibility of Congress to ensure that the additional premiums for catastrophic coverage do not reach such levels as to unreasonably increase the out-of-pocket liability of Medicare beneficiaries.

(2) Sense of the Senate.—Expresses that it is the sense of the Senate that conferees take all necessary steps to ensure that cost controls on new benefits, particularly coverage of prescription drugs, are sufficient to protect program integrity, prevent escalation of costs, and reduce amounts required for premium financing. In addition, it is the sense of the Senate that Senate conferees be instructed to take all feasible steps to minimize beneficiary costs by keeping premiums at the lowest possible level, ensuring that year-to-year premium increases are gradual and predictable, ensuring that the income related premiums do not unduly burden middle-income older Americans, and ensuring that the combined basic and supplemental premiums do not exceed the value of the program to beneficiaries.

Effective date.—(a)–(g) Applies to items and services furnished after December 31, 1987. In determining whether an individual has incurred out-of-pocket medical expenses in 1988 equal to the catastrophic limit, only expenses incurred on or after July 1, 1988, are taken into account. (h) Effective on enactment.

Conference agreement

(a) *In General.*—The conference agreement includes the House provision with an amendment.

(b) *Payment When Limit Has Been Reached.*—The conference agreement includes the House provision.

(c) *Expenses Counting Toward the Catastrophic Limit.*—The conference agreement includes the Senate amendment with a modification. The agreement does not include expenses for Part A cost-sharing, or for preventive services in the calculation of expenses counting toward the catastrophic limit.

The conference agreement, in section 204, provides coverage of screening mammography (including associated professional and technical services) effective January 1, 1990, subject to frequency limitations, quality standards, and special payment rules.

The agreement provides coverage for a biennial screening mammography for women aged 65 and over. For disabled women under age 65, a baseline screening would be available between age 35 and 40. Between ages 40 and 49, screenings would be available every other year, except that screenings could be provided each year for high risk women. Between ages 50 and 64 screenings could be provided on an annual basis.

The agreement requires the Secretary, in consultation with the Director of the National Cancer Institute, to review periodically the appropriate frequency for performing screening mammographies, based on age or other factors. The Secretary, on the basis of this

review, may revise the frequency for covered screenings performed on or after January 1, 1992.

The agreement requires the Secretary to establish standards to assure the safety and accuracy of screening mammographies. The standards must include the following requirements: (i) the equipment used must be specifically designed for mammography and must meet radiologic standards established by the Secretary; (ii) the screening must be performed by an individual who is either licensed by the State to perform radiologic procedures or is certified as qualified to perform such procedures by an appropriate organization recognized by the Secretary; (iii) the results of the mammography must be interpreted by a physician who either is certified by the American Board of Radiology or is otherwise certified by a program recognized by the Secretary by regulation as assuring that the physician is qualified to interpret the results of screening mammography; and (iv) there must be assurances that the results of the first screening paid for by Medicare will be placed in permanent medical records maintained for the woman.

The conferees understand that a bilateral four-view procedure is currently considered to be the standard of care in the United States for screening mammography. The conferees therefore anticipate that this would be initially included in the quality standards to be developed by the Secretary as a requirement for coverage, subject to change with new technology and additional medical information. The conferees also note that the reimbursement level provided for under this provision is premised on the understanding that a four-view procedure would be provided.

State survey and certification agencies and private accreditation programs (if approved) could be used to verify compliance with required quality standards.

Payment would be 80% of the least of: (i) the actual charge, (ii) the fee schedule allownce (with respect to both the professional and technical components of screening mammography) established under Section 1834(b) of the Social Security Act, or (iii) a reasonable charge limit. The limit would be $50 in 1990 and would be indexed thereafter by the percent increase in the Medicare Economic Index (MEI).

Beginning January 1, 1992, the Secretary may reduce the reasonable charge limit, as it applies nationally or in an area, if the Secretary finds such action both appropriate and consistent with maintaining convenient access for beneficiaries to screening services.

The agreement provides for an appropriate allocation of the reasonable charge limit between professional and technical components in the case of hospital outpatient screening mammographies (and comparable situations) where there is a claim for professional services separate from the claim for associated technical services. In these cases, payment for the technical component would be based on the allocated reasonable charge limit.

The agreement sets maximum allowable actual charge (MAAC) limits for screening mammographies performed by nonparticipating physicians. These MAAC limits are based on the fee schedule established for radiologists under Section 1834(b) of the Act.

The MAAC limits are 125% of the reasonable charge limit in 1990, 120% of the reasonable charge limit in 1991, and 115% of the reasonable charge limit in 1991 and subsequent years. The Secretary is empowered to impose sanctions against physicians or suppliers who knowingly and willfully impose charges in excess of the limits.

The MAAC limits would be in effect until such time as the Secretary implements a fee schedule for physicians' services based on the relative value scale mandated under Section 1845(e) of the Social Security Act.

The conferees are aware of concern that the $50 reasonable charge limit might limit the availability of mammography in physicians' offices even though the procedure may be available at clinics, hospital outpatient departments, and outpatient radiology facilities. Accordingly, the conference agreement requires the Physician Payment Review Commission to study the cost of providing screening mammography in a variety of settings and at different volume levels. The report would be submitted to Congress by July 1, 1990.

Finally, the conference agreement requires GAO to conduct a study of the quality of screening mammography provided in clinics, hospital outpatient departments, and outpatient radiology facilities as compared with physician offices. This report would also be due by July 1, 1990.

(d) *Catastrophic Limit.*—The conference agreement includes the Senate amendment with a modification. The agreement sets the Part B catastrophic limit for 1990 at $1370. The agreement requires the Secretary to set the limit for future years at an amount necessary to ensure that the percentage of Part B enrollees (not including enrollees in health maintenance organizations) whose expenses are expected to exceed the cap during that year is 7 percent.

The conference agreement requires the Secretary to promulgate, not later than September 1 of each year (beginning in 1990), the catastrophic limit which will be in effect for the following calendar year.

(e) *Payments to Prepaid Health Plans Paid on a Reasonable Cost Basis.*—The conference agreement includes the House provision, with amendments. The provisions relating to charges for covered services after an individual has reached the catastrophic limit apply to organizations with a risksharing contract, as well as to those paid on a reasonable cost basis. Different rules apply depending on whether the organization does or does not "buy out" Part B deductible and coinsurance charges for enrolled beneficiaries. A plan is deemed to be a buy-out plan if the actuarial value of the coinsurance and deductible charges it imposes on enrollees for Part B services (other than for outpatient drugs) is less than 50 percent of the national average actuarial value of the Part B coinsurance and deductible for all Medicare beneficiaries.

In the case of a buy-out plan, actual cost-sharing amounts for Part B services incurred by a beneficiary while enrolled in the plan are not counted towards the catastrophic limit. However, the enrollee is deemed to have incurred Part B cost-sharing expenses for each month of enrollment equal to the monthly national average actuarial value of Part B deductible and coinsurance amounts.

In the case of a plan than is not a buy-out plan, cost-sharing amounts for Part B services incurred by a beneficiary while enrolled in the plan are counted towards the catastrophic limit. The plan may not enter into a Medicare contract or receive Medicare payment unless it provides assurance satisfactory to the Secretary that: (i) it will maintain, in coordination with the appropriate Part B carriers, accounts of Part B cost-sharing expenses incurred by enrollees during each year, including out-of-plan services; (ii) it will make the accounts available to an enrollee and to the carrier if an enrollee disenrolls during the year (or at any time, in the case of an organization paid under section 1833); and (iii) it will not undertake to charge any enrollee for Part B services (other than outpatient drugs) after the enrollee has incurred cost-sharing expenses, whether through the organization or otherwise, equal to the catastrophic limit for the year.

The conferees expect that the Secretary, in establishing contracts with Part B carriers under section 1842, will require the carriers to provide information on expenses for out-of-plan services to the plans without charge.

If a beneficiary is enrolled in a plan which has its contract terminated by the Secretary during a year, no inpatient hospital deductible will be imposed on an individual who can demonstrate to the satisfaction of the Secretary that he or she was admitted to a hospital during the calendar year.

(f) *Limitation on Charges When Catastrophic Limit Reached.*—The conference agreement includes the Senate amendment.

(g) *Notice for Beneficiaries Reaching Catastrophic Limit.*—The conference agreement includes the House provision with a modification. The required notice is to state that the individual has reached the Part B catastrophic limit for the year.

(h) *Beneficiary Costs of Catastrophic Insurance.*—The conference agreement does not include the Senate amendment. The amendment expressed the sense of the Senate, and was duly passed by the Senate.

Effective date.—The conference agreement applies to items and services furnished on and after January 1, 1990.

10. Coverage of Catastrophic Expenses for Prescription Drugs (Section 202 of House bill; Sections 11 and 28 of Senate amendment)

Present law

Medicare generally does not cover outpatient prescription drugs which can be self-administered by the patient. The program covers under Part B immunosuppressive drugs which are furnished within one year of an organ transplant covered by Medicare.

House bill

(a) In General.—Adds "covered outpatient drugs" to services included within the definition of "medical and other health services". Defines a "covered outpatient drug" as one that is: (1) approved for safety and effectiveness under the Federal Food, Drug, and Cosmetic Act, or, in the case of a drug which is a biological product, is licensed under the Public Health Service Act; and (2) insulin certi-

fied under the Federal Food, Drug, and Cosmetic Act. The term does not include any drug or insulin provided to an inpatient as part of inpatient hospital services, extended care services, or incident to physicians' services. The term does not include immunosuppressive drugs which are furnished within 1 year of a covered organ transplant.

(b) Phase-In Coverage.—No provision.

(c) Deductible.—

(1) Provides that expenses for covered outpatient drugs do not count toward the Part B deductible and that the Part B deductible is not applicable for covered outpatient drugs.

(2) Requires the individual, before the program makes payments for covered outpatient drugs, to establish that he has incurred (or has had paid in his behalf) expenses for covered outpatient drugs during the year equal to the drug deductible. The Secretary is required, upon application by the individual, to promptly notify the individual (and, if submitted by or through a participating pharmacy, the pharmacy) as to whether he has met the deductible.

(3) Sets the deductible at $500 in 1989. The increase in 1990 and 1991 is equal to the increase in the medical care component of the consumer price index (for the 1-year period ending the previous August). In future years, it is increased by the percentage increase in the outpatient prescription drug index established by the Secretary. The base point of the index is the prices of covered outpatient drugs as of August 1990. In September of each year (beginning in 1991), the Secretary is to determine the percentage change for the preceding 12 months (rounded to the nearest dollar). The Secretary is required to publish the deductible each year beginning in 1989.

(d) Adjustment in Deductible.—Provides for an adjustment if the Secretary's estimate of the additional Part B premium needed to finance the drug benefit indicates an increase of more than 20 percent over the previous year. In this case, the Secretary would increase the deductible by an amount sufficient to reduce the costs of the program to the level that would be financed by a 20 percent premium increase. (The premium is to cover 75 percent of total costs of the drug benefit; see Item 15.)

(e) Authority to Reduce Deductible—No provision.

(f) Payment Amount.—

(1) Specifies that, subject to the deductible, the amount paid with respect to a covered outpatient drug is equal to lesser of the actual charge or the applicable payment limit minus 20 percent of the actual charge. The payment amounts are also applicable for payments for immunosuppressive drugs during the first year following a covered organ transplant.

(2) Specifies that the payment calculation periods are the 6-month periods beginning with January and July of each year.

(3) Requires the Secretary, (before each 6-month payment calculation period beginning on or after January 1, 1989), to provide information on payment limits to participating pharmacies and groups representing or assisting beneficiaries.

(4) Requires the Secretary to provide for an appropriate adjustment to payment rates for prepaid health plans paid on a

reasonable cost basis to reflect the new catastrophic drug benefit. The adjustment is to reflect: (A) the aggregate increase in payments which would otherwise be made for enrollees if they were not enrolled in the organization; or (B) the amount that would be paid to the organization or a facility if payments were made on an individual by individual basis. The organization is required to provide assurances, satisfactory to the Secretary, that it will not undertake to charge an individual more than 20 percent of the reasonable cost plus any amount needed to satisfy the deductible.

(g) Payment Limits for Non-Multiple Source Drugs and Drugs With Restrictive Prescriptions.—

(1) Provides that the payment limit for a drug which is either not a multiple source drug or a multiple source drug with a restrictive prescription is the sum of: (A) the product of the number of dosage units or tablet units and the average per tablet or unit wholesale price; plus (B) an administrative allowance.

(2) Requires the Secretary to determine (with respect to dispensing a covered outpatient drug in a payment calculation period beginning on or after January 1, 1989) the average per tablet or unit wholesale price based on the average wholesale price for purchases in reasonable quantities. The determination is to be based on wholesale prices for the first day of the third month before the beginning of the payment calculation period. The determination and calculation of the payment limits are to be made on a national basis, except that the determination and calculation may be done on a regional basis to take into account limitations in availability or variations in average wholesale prices for a drug product.

(3) Specifies that a drug has a restrictive prescription only if the prescription indicates, in the handwriting of the physician (or other person prescribing the drug), and with an appropriate phrase recognized by the Secretary, that the particular drug must be dispensed. An appropriate phrase may be "brand medically necessary)."

(h) Payment Limit for Multiple Source Drugs Without Restrictive Prescriptions.—

(1) Provides that the payment limit for a multiple source drug without a restrictive prescription is the sum of: (A) the product of the number of tablets or dosage units and the unit limit, plus (B) the administrative allowance. Specifies that the unit limit is 50 percent of the brand name reference price for the reference drug product for the period.

(2) Requires the Secretary to establish a brand name reference price for each reference drug product for each payment calculation period. For the 6-month period beginning January 1, 1987, the brand name reference price for a drug product is the average per tablet or unit wholesale price (based on purchases of reasonable quantities) as of January 1, 1987.

Specifies that for each subsequent 6-month payment calculation period, the reference price is increased by the increase in the consumer price index (for the 6-month period ending in the third month of the previous calculation period).

Specifies that for a reference drug product which was not available on January 1, 1987, the base period is the first month of the first payment calculation period in which it is available.

Specifies that brand name reference prices are to be established on a national basis, except that the prices may be established on a regional basis to take into account limitations in availability or variations in the average wholesale price for a drug product.

(3) Defines a multiple source drug as a covered outpatient drug for which (during the payment calculation period) there are 2 or more drug products which: (A) are rated thereapeutically equivalent under the Food and Drug Administration's most recent publication of "Approved Drug Products With Therapeutic Equivalence Evaluations" which is available on the first day of the third month before the beginning of the period; and (B) are sold or marketed during the period.

Specifies that a drug is considered as sold or marketed if it listed in the FDA publication unless the Secretary determines that the sale or marketing is not actually taking place.

(4) Defines a "reference drug period" as a multiple source drug in reference to which other drug products are rated as therapeutically equivalent in the FDA publication.

(i) Administrative Allowance.—Specifies that the administrative allowance is $4.50 for drugs dispensed in a payment calculation period beginning in 1989. For each subsequent payment calculation period, the administrative allowance is increased by the percentage increase (if any) in the implicit price deflator for gross national product.

(j) Assuring Appropriate Utilization.—

(1) Provides that the Secretary may provide that payment for covered outpatient drugs may not be made if they are prescribed or dispensed with excessive frequency or in excessive quantities. The Secretary is required to establish a utilization review program for covered outpatient drugs to identify instances of unnecessary or inappropriate prescribing or dispensing practices and to identify quality of care problems.

(2) No provision.

(k) Treatment of Certain Prepaid Organizations.—Establishes rules with respect to prepaid organizations which do not impose charges on covered outpatient drugs. For purposes of the drug provision, the actual charges of the organization are the organization's standard charges to members and other persons not entitled to drug benefits. The standard charges are to be used for purposes of the drug deductible.

(l) Physician Guide.—Requires the Secretary to develop, and update annually an information guide for physicians on the comparative average wholesale prices of at least 500 of the most commonly prescribed covered outpatient prescription drugs. To the extent practicable, the guide is to group drugs in a manner useful to physicians by therapeutic category or conditions for which they are prescribed. The guide is to specify the wholesale prices on the basis of the amount required for a typical daily therapeutic regimen. The Secretary is required to mail the guide by March 1 of each year (beginning in 1989) to each hospital with a provider

agreement with Medicare and each physician who routinely provides Medicare services.

(m) Special Cost-control Measures.—No provision. See Item 10(d) on adjustment in deductible for requirement that Secretary increase drug benefit deductible to prevent excessive increase in premiums.

(n) High Volume Pharmacies.—No provision.

(o) Report on Payment Limits.—Requires the Secretary to review the payment limits established for covered outpatient drugs and report to Congress by April 1, 1989, on the appropriateness of the limits, together with any recommendations for change.

(p) Report on Covered Outpatient Drug Index.—Requires the Secretary to report to Congress by January 1, 1991, on the covered outpatient drug index.

(q) Participating Pharmacies.—

(1) Defines a participating pharmacy as one which is authorized under State law to dispense covered outpatient drugs and which has entered into an agreement with the Secretary. Under the agreement, the entity agrees:

(A) Not to refuse to dispense covered outpatient drug items, stocked by the entity, to Medicare Part B beneficiaries and not to charge them more for such drugs than charged to the general public;

(B) To keep patient records (including records on expenses incurred by beneficiaries) for all covered outpatient drugs dispensed to beneficiaries;

(C) To assist beneficiaries in determining whether they have met the drug deductible including providing the necessary documentation;

(D) To provide, upon request of a beneficiary, a copy of his records to another participating pharmacy or Medicare carrier;

(E) To offer to counsel or offer to provide information to each beneficiary on the appropriate use of a dispensed drug and whether there are potential interactions between this drug and others dispensed to the beneficiary;

(F) To advise the beneficiary on the availability (consistent with State drug substitution laws) of therapeutically equivalent covered outpatient prescription drugs; and

(G) To submit, effective January 1, 1992, all claims requests electronically, except this requirement may be waived by the Secretary in cases of undue hardship.

Pharmacies operated by prepaid organizations for the exclusive benefit of its members are not required to dispense covered outpatient drugs to nonmembers.

(2) Requires the Secretary to provide each participating pharmacy with a distinctive emblem and, before each payment calculation period, information on payment limits established under the drug benefit.

(3) Requires the Secretary to provide for periodic audits of participating pharmacies to insure that they do not impose charges on beneficiaries in excess of those charged to the general public.

(4) Payments for covered outpatient drugs may only be made on an assignment basis in the case of participating pharmacies.

(r) Civil Monetary Penalty.—No provision.

(s) Limitation to 60 Day Prescription.—Prohibits Part B payments for covered outpatient drugs if dispensed in excess of a 60-day supply.

(t) Additional Premium for Prescription Drug Benefit.—Refers to section 106(a) of the bill. (See Item 15.)

(u) Use of Carriers in Administration.—

(1) Requires carriers making determinations or payments with respect to covered outpatient drugs to: (A) offer to receive payment requests electronically; and (B) respond to requests by participating pharmacies as to whether an individual has met the deductible. The Secretary may enter into agreements for processing of drug claims on a regional basis.

(2) No provision.

(v) Modification of HMO/CMP Provisions.—

(1) Requires HMOs and CMPs with Medicare risk sharing contracts to take into account drug expenses incurred in a year by individuals who enroll after January 1 of a year.

(2) No provision.

(3) No provision.

(w) Medicaid Requirements.—See Item 33.

(x) Beneficiary Drug Cost Survey and CBO Report.—

(1) Requires the Secretary to conduct a statistically valid survey, and report to Congress by March 1, 1989, on expenses incurred by beneficiaries for covered outpatient drugs. The Secretary is required to consult with the General Accounting Office (GAO) and the Congressional Budget Office (CBO) concerning survey design. The survey is to provide information on the distribution of expenses for covered outpatient drugs for Medicare beneficiaries generally and the distribution of expenses by age, sex, income, and institutional status.

(2) Requires the CBO (within 2 months of submission of the report) to estimate Medicare expenditures for fiscal year 1990–93 for covered outpatient drugs.

(3) No provision.

(y) Prescription Drug Payment Review Commission.—Requires the Director of the Office of Technology Assessment (OTA) to provide for the appointment of a Prescription Drug Payment Review Commission to be composed of individuals with expertise in the provision and financing of covered outpatient prescription drugs. The Director of OTA shall appoint the 11 Commission members by October 1, 1988, for staggered 3-year terms. The membership must include recognized experts in health care economics, medicine, pharmacology, pharmacy, and prescription drug reimbursement, as well as one Medicare beneficary. The Commission is required to make annual recommendations to the Secretary.

(z) Additional Studies.—

(1) Requires the Secretary to conduct studies on:

(A) Extent of private or other third-party drug coverage for beneficiaries;

(B) Comparison of published average wholesale price and actual pharmacy acquisition costs by type of pharmacy;

(C) Overhead costs of retail pharmacies;

(D) Potential application of new claims processing and billing technologies;

(E) Methods for utilization review;

(F) Alternative payment methodologies that promote greater program efficiencies; and

(G) Potential for induced demand resulting from the drug benefit.

(2) Requires the Secretary, as part of the studies, to conduct a longitudinal study on the use of covered outpatient drugs by beneficiaries with respect to medical necessity, potential for adverse drug interactions, and patient stockpiling or wastage. The Secretary is required to report to Congress on the results of the studies by January 1, 1991.

(3) No provision.

(aa) Study of Treatment of Prescription Drugs.—No provision.

(bb) Simplification of Recordkeeping.—No provision.

Effective date.—Applies to drugs dispensed on or after January 1, 1989. (u) and (y) effective on enactment. (v) applies to new enrollments effected on or after January 1, 1989.

Senate amendment

(a) In General.—Adds "covered outpatient drugs" to services included within the definition of "medical and other health services". Defines a covered outpatient drug as one which is: (1) approved for safety and effectiveness under the Federal Food, Drug, and Cosmetic Act, or is recognized in the "United States Pharmacopoeia" (and is available only under a prescription); or (2) in the case of a prescription drug which is a biological product, is licensed under the Public Health Service Act. The term does not include any drug or biological which would have been paid for under Medicare prior to enactment of this law. The term does not include immunosuppressive drugs which are furnished during the first year following a covered transplant.

(b) Phase-In Coverage.—

(1) Specifies that in 1990, the term covered outpatient drug includes a drug which is an intraveneously administered antiinfective agent, a cancer chemotherapeutic agent (including a drug used to enhance the safety and efficacy or counteract the toxicity of anticancer drugs) or immunosuppressive drugs after the first year following a covered organ transplant.

(2) Specifies that in 1991 and 1992, the term covered outpatient drug includes drugs specified under item (1) and any cardiovascular or diuretic drug.

(c) Deductible.—

(1) Similar provision.

(2) Identical provision.

(3) Sets the deductible at $600 in 1990. In subsequent years, it is increased by the percentage by which the Part B beneficiary drug expenditure amount for the 12-month period ending the previous August exceeds such amount for the preceding 12 months (rounded to the nearest dollar). [See Item 15 below for definition of beneficiary drug expenditure amount.] The Secre-

tary is required to publish each September (beginning in 1990) the deductible for the following year.

(d) Adjustment in Deductible.—No provision.

(e) Authority to Reduce Deductible.—Provides that if the Secretary determines there is sufficient revenue to pay all of the benefits and administrative costs, and to provide an adequate contingency margin (as determined by the Secretary), the Secretary may reduce the deductible amount to $500 in 1991, $400 in 1992, and $300 in 1993.

(f) Payment Amount.—

(1) Similar provision, except specifies that the applicable payment limit is subject to reductions applied to high volume pharmacies.

(2) Specifies that the payment calculation period is the 12-month period beginning every January (after 1989).

(3) Similar provision except: (A) applies to payment calculation periods beginning on or after January 1, 1990; and (B) also requires provision of information on any reductions applied for high volume pharmacies.

(4) Permits a prepaid health plan paid on a reasonable cost basis to elect to be paid 80 percent of the reasonable cost of immunosuppressive and covered outpatient drugs. Such organization may not charge individuals more than 20 percent of the reasonable cost plus any amount needed to satisfy the deductible.

(g) Payment Limits for Non-Multiple Source Drugs and Drugs With Restrictive Prescriptions.—

(1) Similar provision.

(2) Similar provision except: (A) applies to determinations for payment calculation periods beginning on or after January 1, 1990; (B) specifies that the average per tablet or unit wholesale price is the most recently published figure; and (C) requires the calculation to be made on a national basis if the drug is available on a national basis.

(3) Similar provision, except applies to written prescriptions. Specifies that for telephone prescriptions, the physician or other person (through the use of an appropriate phrase) states that the particular drug must be dispensed.

(h) Payment Limit for Multiple Source Drugs Without Restrictive Prescriptions.—

(1) Provides that the payment limit for a multiple source drug without a restrictive prescription is the sum of (A) the product of the number of tablets (or other dosage units) and 150 percent of the lowest average per tablet or unit wholesale price for the drug; and (B) the administrative allowance.

(2) Requires the Secretary to determine with respect to covered outpatient drugs for the payment calculation period (beginning on or after January 1, 1990) the average per tablet or per unit wholesale price for the drug for purchases in reasonable quantities. Specifies that for the period beginning January 1, 1987, the average is the average per tablet or per unit wholesale price for the drug as of January 1, 1987.

Specifies that for subsequent payment calculation periods, the amount is the lesser of: (A) the most recently published av-

erage per tablet or per unit wholesale price; or (B) the average per tablet or unit price established for the previous payment calculation period increased by the percentage change in the Consumer Price Index for the 12-month period ending the preceding August.

Requires the Secretary to establish the average per tablet or per unit wholesale price, in the case of a covered outpatient drug which is not available as of January 1, 1987, for the first month of the first payment calculation period in which it is available.

Requires the Secretary to make determinations on a national basis if the drug is available on a national basis. If not, the Secretary may make determinations and calculate payment limits on a regional basis to take into account the availability of drug products and variations in average wholesale prices.

(3) Defines a multiple source drug as a covered outpatient drug for which (during the payment calculation period), there are 2 or more drug products (or in the case of a covered outpatient drug subject to a patent, 3 or more drug products) generally available to beneficiaries through retail pharmacies which the Secretary determines are: (A) pharmaceutically equivalent, bioequivalent, adequately labeled, and manufactured in compliance with the Current Good Manufacturing Practice regulations; and (B) sold or marketed during the period.

Specifies that drug products are pharmaceutically equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form and meet compendial or other applicable standards of strength, quality, purity, and identity. Drugs are bioequivalent if they do not present a known or potential bioequivalence problem, or if they do present such a problem, are shown to meet an appropriate bioequivalence standard.

Specifies that a drug is considered to be sold or marketed during a period if it is listed in the Food and Drug Administration's most recent publication of "Approved Drug Products With Therapeutic Equivalance Evaluations" for the third month before the beginning of the period, unless the Secretary determines that such sale or marketing is not actually taking place.

(4) No provision.

(i) Administrative Allowance.—Similar provision, except: (A) administrative allowance is $3.50 for nonparticipating pharmacies for the payment calculation period beginning January 1, 1990; and (B) the amounts are increased annually rather than biannually.

(j) Assuring Appropriate Utilization.—

(1) Provides that the Secretary may provide that payment for covered outpatient drugs may not be made in specific instances if they are prescribed or dispensed with excessive frequency or in excessive quantities. The Secretary is required to establish a utilization review program for covered outpatient drugs to identify patterns of unnecessary or inappropriate prescribing or dispensing practices, including excessive charging in the dispensing of drugs and to identify patterns of substandard care.

(2) Requires the Secretary in carrying out the utilization review program, to use diagnosis and indication codes and establish standards for the prescribing, dispensing, and utilization for each covered outpatient drug. In establishing the standards, the Secretary (after providing notice in the Federal Register and not less than a 60-day comment period) may incorporate standards from current authoritative medical references as he may select.

(k) Treatment of Certain Prepaid Organizations.—Identical provision.

(l) Physician Guide.—Similar provision, except guide must be mailed by January 1 of each year (beginning in 1990).

(m) Special Cost-Control Measures.—Requires the Secretary to institute necessary cost control measures if he determines that the monthly catastrophic drug benefit premium will exceed the limits established under this bill. (See Item 15.) In carrying out this provision, the Secretary may not exclude from coverage or limit payment for any specific covered outpatient drug or specific class of covered outpatient drugs or change the methodology for calculating whether the individual has met the deductible. However, the Secretary may exclude from coverage all drugs listed in a major classification of the most recently issued version of Veterans' Administration Medication Classification System.

(n) High Volume Pharmacies.—Authorizes the Secretary, after 1990, to reduce by regulation the payment limits established (both for nonmultiple source and multiple source drugs) dispensed by a high volume pharmacy (as defined by the Secretary). The reductions are to be based on differences between high volume pharmacies and other pharmacies with respect to operating costs, quantity discounts, and other economies. The Secretary is required to consult with high volume pharmacists, elderly groups and private insurers in making such adjustments. A minimum 90-day public comment period is required for proposed regulations.

(o) Report on Payment Limits.—Requires the OTA and the Secretary to submit to the Congress before beginning of the calendar year (for years after 1990) recommendations for adjustments to the payment limits. The Secretary is required to request the National Academy of Sciences, acting through the Institute of Medicine, to enter into a contract to make such recommendations. Each is required to consult with pharmacists, pharmaceutical manufacturers, elderly groups, and private insurers in making such recommendations.

(p) Report on Covered Outpatient Drug Index.—No provision.

(q) Participating Pharmacies.—

(1) Similar provision except:

(A) Does not apply in the case of any entity which dispenses covered outpatient drugs exclusively to beneficiaries enrolled in HMOs and CMPs;

(B) Identical provision;

(C) To assist beneficiaries in determining whether or not their expenses for covered outpatient drugs exceed the deductible and to certify to the Secretary, with respect to such beneficiaries that their expenses exceed the deductible and make available supporting documentation. Noth-

ing is to be construed as authorizing the Secretary to require submission of the documentation with respect to prescriptions other than pursuant to an audit, upon certification under this provision, or for monitoring purposes from a sample of up to 7.5 percent of participating pharmacies;

(D) Identical provision;

(E) Specifies that the provision of information to beneficiaries is to be consistent with State law respecting the provision of such information;

(F) Identical provision;

(G) Changes the effective date to January 1, 1991.

(2) Identical provision.

(3) Identical provision.

(4) Identical provision.

(r) Civil Monetary Penalty.—Provides that civil monetary penalties may be imposed in the case of participating or nonparticipating pharmacy which presents, or causes to be presented, a request for payment for covered outpatient drugs at a charge greater than that charged the general public.

(s) Limitation to 60 Day Prescription.—Similar provision except permits up to a 90 day supply in the case of an individual receiving chronic maintenance drug therapy as defined by the Secretary.

(t) Additional Premium for Prescription Drug Benefit.—No specific cross reference (See Item 15).

(u) Use of Carriers in Administration.—

(1) Similar provision, except includes fiscal intermediaries in title.

(2) Specifies that 95 percent of clean claims for covered outpatient drugs are to be paid within 45 days of receipt.

Specifies that contracts with carriers shall provide that no payment shall be issued, mailed, or otherwise transmitted for covered outpatient drugs within 30 days after the claim is received.

(3) Authorizes the Secretary to enter into contracts with intermediaries and carriers for performance of functions relating to home intravenous drug therapy on a regional basis.

(v) Modification of HMO/CMP Provisions.—

(1) Identical provision.

(2) Specifies that the calculation of the premium rate and the actuarial value of the deductible and coinsurance for individuals enrolled only in Part A or Part B is to be made separately for the drug benefit.

(3) Specifies that additional benefits required to be provided by an HMO/CMP may include reduction of premium rate or other charges made with respect to drugs.

(w) Medicaid Requirements.—See Item 33.

(x) Beneficiary Drug Cost Survey and CBO Report.—

(1) Similar provision, except requires the Secretary also to consult with consumer groups and representatives of the pharmaceutical and pharmacist industries. Report on survey due by January 19, 1989.

(2) Identical provision.

(3) Requires the GAO (within 2 months of submission of the report) to report on the validity of the survey and the extent to

which pharmacies accept assignment and barriers, if any, to such acceptance.

(y) Prescription Drug Payment Review Commission.—No provision.

(z) Additional Studies.—

(1) Similar provision, except does not include Item B. Adds study requirement on the possibility of including drugs which have not yet been approved under the Federal Food, Drug, and Cosmetic Act, but which are commonly used in the treatment of cancer or immunosuppressive therapy as covered outpatient drugs. The study shall be conducted in consultation with an advisory board of consumers, experts in the field of cancer therapy and immunosuppressive therapy, representatives of pharmaceutical manufacturers, and such other individuals as the Secretary may select.

(2) Similar provision except requires an interim report by not later than January 1989.

(3) Requires the Secretary and the GAO to each conduct and periodically update a study on comparison of published average wholesale prices and actual pharmacy acquisition costs by type of pharmacy. A report is to be sumitted to Congress on the results of each study and update with the first report due no later than January 1, 1989.

(aa) Study of Treatment of Prescription Drugs.—

(1) Requires the OTA to conduct a study to identify additional or alternative covered outpatient drugs that can be included under the Medicare definition for 1991 and 1992.

(2) Requires the Secretary to request the National Academy of Sciences, through the Institute of Medicine, to enter into a contract under which the Institute, in consultation with representatives of appropriate research and health care organizations, will also conduct the study described in (1). The Secretary is to be responsible for related expenses incurred by the Academy.

Specifies that in conducting the study, the Office and the Institute are to give particular attention to those drugs that meet any or all of the following criteria:

(A) The drug is used by a large number of beneficiaries;

(B) The drug can be covered without significant administrative difficulties;

(C) Coverage will provide useful information with respect to utilization and cost of covered outpatient drugs under Medicare;

(D) Coverage will not cause an unreasonble increase in premiums under Medicare;

(E) The drug is expensive when used as part of a chronic drug regimen.

Requires the OTA and the Institute to submit to the Secretary and appropriate congressional committees an interim report within 6 months of enactment, and a final report containing specific findings and recommendations within 12 months.

(bb) Simplification of Recordkeeping.—Requires the Secretary, by October 1, 1988, to enter into an agreement with two or more pri-

vate entities to conduct demonstration projects to test the use of magnetic cards, electronic billing, and other technological devices in the administration of the drug benefit.

Specifies that the Secretary shall select among applications submitted by entities in the form prescribed by the Secretary. The Secretary shall determine the time necessary to carry out the project and submit a report within 6 months of completion.

Specifies that the projects are to be conducted at statistically relevant locations and be used for providing quick data for projecting total cost of the drug benefit.

Requires the Secretary to develop, in consultation with representatives of participating pharmacies, consumers, and other interested individuals, a standard receipt to be used by Medicare beneficiaries in making purchases from participating pharmacies. The receipt is to be distributed by January 1, 1990. The Secretary is to take appropriate steps to insure that such pharmacies used the receipt.

Effective date.—Enactment.

Conference agreement

(a) *In General.*—The conference agreement includes the House provision with an amendment. The agreement includes coverage for two additional categories of prescription drugs. The first category includes those drugs (i) which were commercially used or sold prior to the Drug Amendments of 1962 and (ii) which are identical, similar or related to those described in clause (i) provided that the Secretary has not made a final determination that the drugs described in clause (i) or (ii) are "new drugs." These drugs are the so-called "pre-1938" drugs and are not subject to current requirements regarding pre-market approval by the Food and Drug Administration (FDA) for safety and efficacy.

The conference agreement also includes coverage for certain so-called DESI drugs. Under the provisions of the 1962 amendments to the Federal Food, Drug, and Cosmetic Act, all new drugs must be shown to be effective and safe rather than just safe as had been required previously. This legislation also applied retroactively to all drugs approved as safe from 1938 to 1962. The program established to review the effectiveness of these drugs was named the Drug Efficacy Study Implementation (DESI) program. Under the program, drugs were labelled effective, probably effective, possibly effective, or ineffective. The FDA reviewed any additional evidence submitted by the manufacturer for those drugs determined to be less than effective. If the FDA decides that a drug product lacks substantial evidence of effectiveness for the conditions it is intended to treat, it publishes a notice of opportunity for hearing in the Federal Register on a proposal to withdraw approval for marketing. This affords the manufacturer an opportunity for a hearing before a final determination is made. The conference agreement includes coverage for DESI drugs for which the Secretary has not issued a notice for an opportunity for a hearing and for which the Secretary has determined there is compelling justification for its medical need. Also included are identical, similar or related drugs. It is the understanding of the conferees that the only DESI drug which would be covered by this provision, because a notice for an

opportunity for a hearing has not been issued, is nitroglycerin patches.

The agreement further clarifies that the term "covered outpatient drugs" does not include drugs which are already being reimbursed under current law because they are provided as part of, or incident, to other covered services.

(b) *Phase-in Coverage.*—The conference agreement includes the Senate amendment with modifications. The agreement provides coverage for two categories of drugs in 1990—drugs used in immunosuppressive therapy and covered home intravenous (IV) drugs.

Drugs used in immunosuppressive therapy are currently covered for only one year after a transplant that is covered by Medicare. The conference agreement would retain this coverage, which would remain subject to current rules on coinsurance. The conference agreement would add subsequent coverage as well, irrespective of whether the transplant was covered by Medicare. This subsequent coverage would be subject to the same rules regarding deductible and coinsurance as apply to other newly covered prescription drugs.

The agreement provides for coverage of all "covered outpatient prescription drugs" effective January 1, 1991. The agreement provides for a phase-in of the benefit by reducing the requisite beneficiary coinsurance over a three-year period.

Coinsurance is set at 50% in FY 1990 and FY 1991, 40% in FY 1992, and 20% in FY 1993 and each year thereafter. The agreement limits coinsurance to 20%, starting in 1990 with no phase-in, for home IV drugs and immunosuppressive drugs used during the first year after a Medicare covered transplant. (For subsequent use of immunosuppressive drugs, coinsurance would be determined by the general rule.)

The agreement defines a covered home IV drug as one that is intravenously administered in a home setting. The term includes antibiotic drugs, unless the Secretary has determined, for a specific drug or for the indication for which it is applied, that it cannot generally be safely or effectively administered in a home setting. The term includes additional IV drugs (other than antibiotics) only if the Secretary determines that for the specific drug and the indication for which it is being applied, that it can generally be administered safely and effectively in a home setting. The Secretary could establish guidelines or precautions necessary to assure the safety and effectiveness of specific IV drugs in a home setting.

The agreement does not require the Secretary to consult with an advisory panel in making these determinations. The conferees note that the Secretary could refer review of safety and effectiveness issues to the Public Health Service's Office of Health Technology Assessment.

The conferees expect that the Secretary will complete a review of the safety and effectiveness of home IV cancer chemotherapy drugs as soon as possible.

A drug, which would otherwise be covered as an outpatient drug, is excluded from coverage if the drug is intravenously administered in a home setting and does not satisfy the definition of a covered home IV drug.

(c) *Deductible.*—

(1) The conference agreement includes the Senate amendment.

(2) The conference agreement includes the House provision. In determining whether a beneficiary has met the deductible, the Secretary would count all expenses paid on behalf of the beneficiary, such as those paid pursuant to an insurance policy. In calculating the deductible, the Secretary must include amounts actually paid by the beneficiary (or on the beneficiary's behalf) and may not reduce such amounts by applying Medicare payment screens below the deductible.

(3) The conference agreement includes the Senate amendment with a modification. The agreement sets the deductible at $550 in 1990, $600 in 1991, and $652 in 1992. In future years the deductible will be indexed so as to ensure that the percentage of Part B enrollees (not including enrollees in health maintenance organizations) whose expenses for covered outpatient drugs are expected to exceed the deductible during that year is 16.8%. This is the same percentage as the percentage of enrollees whose costs are expected to exceed the deductible in 1991. The conference agreement specifies a deductible for 1992 in the law rather than relying on indexing by the Secretary, because actual program data necessary for reliable indexation would not be available in time for setting the 1992 deductible.

The agreement requires the Secretary to publish by May 1 of each year (beginning in 1992) a proposed regulation establishing the deductible for the next year. The Secretary would be required to publish a final regulation during the last 3 days of September. The final deductible established in September may not exceed deductible proposed in May.

The conference agreement provides that the drug deductible will not apply for home IV drugs dispensed as part of a continuous course of therapy initiated while the beneficiary was a hospital inpatient. Further, the drug deductible does not apply with respect to immunosuppressive drugs furnished within one year following a covered organ transplant.

(d) *Adjustment in Deductible.*—The conference agreement does not include the House provision.

(e) *Authority To Reduce Deductible.*—The conference agreement does not include the Senate amendment. Because the deductible after 1992 will be indexed to ensure that 16.8% of beneficiaries reach the deductible, the Secretary would be authorized to lower or raise the deductible.

(f) *Payment Amount.*—

(1) The conference agreement includes the Senate amendment with a modification. The agreement specifies that the amount paid for a covered outpatient drug is equal to the "payment percent" multiplied by the lesser of the actual charge or the applicable payment limit. The payment percent is 100% minus the required coinsurance. Thus, in 1990 (and thereafter), the payment percent is 80% for home IV drugs and for immunosuppressive drugs used during the first year post transplant. The payment percent for other covered outpatient drugs is 50% in 1990 and 1991, 60% in 1992, and 80% thereafter.

The agreement deletes the reference to high volume pharmacies.

(2) The conference agreement includes the House provision with an amendment specifying that the first payment calculation period begins January 1, 1990.

(3) The conference agreement deletes the Senate amendment requiring that the information on payment limits be provided on a list sent to pharmacies. The conferees note, however, that this information will be available through the electronic system. The reference to high volume pharmacies also is deleted.

(4) The conference agreement includes the Senate amendment, with modifications. The provisions relating to charges for covered services after an individual has met the catastrophic deductible for outpatient drugs apply to organizations with a risk-sharing contract and those paid on a reasonable cost basis as well as to those health care prepayment plans that have elected to provide the catastrophic drug benefit. Different rules apply depending on whether the organization does or does not "buy out" drug charges below the catastrophic deductible amount for enrolled beneficiaries. A plan is deemed to be a buy-out plan if the deductible charge it imposes on enrolles for covered outpatient drugs is less than 50 percent of the Medicare catastrophic deductible for outpatient drugs.

In the case of a buy-out plan, actual expenses for outpatient drugs incurred by a beneficiary while enrolled in the plan are not counted towards the catastrophic limit. However, if an enrollee disenrolls during a year, he or she is deemed to have incurred expenses for covered drugs during each month of enrollment during the year equal to the monthly national average drug expenses during that year for all Medicare beneficiaries. The Secretary is required, in December of each year, to estimate the national average expense for covered drugs for the following year.

In the case of a plan that is not a buy-out plan, expenses for covered outpatient drugs incurred by a beneficiary while enrolled in the plan are counted towards the catastrophic limit. The plan may not enter into a Medicare contract or receive Medicare payment unless it provides assurances satisfactory to the Secretary that: (i) it will maintain, in coordination with the Part B carriers, accounts of expenses for covered drugs incurred by or on behalf of enrollees during each year, and will make the accounts available to an enrollee and to the carrier if an enrollee disenrolls during the year; and (ii) in determining whether an enrollee has met any deductible under its own plan, the organization will take into account all those expenses for covered drugs that are to be counted towards the catastrophic drug deductible.

The conferees expected that the Secretary, in establishing contracts with Part B carriers under section 1842, will require the carriers to provide information on expenses for out-of-plan services to the plans without charge.

(g) *Payment Limits for Non-Multiple Source Drugs and Multiple Source Drugs With Restrictive Prescriptions.*—

(1) The conference agreement includes the House provision with a modification. The Medicare payment limit for a single

source drug or a multiple source drugs with a restrictive prescription is the lessor of:

(A) the 90th percentile of actual charges for the drug adjusted (as appropriate by the Secretary) to reflect the number of dosage units or tablet units dispensed; or

(B) the administrative allowance plus the number of tablets or dosage units dispensed times the per tablet or per unit average wholesale price. The agreement specifies that the 90th percentile limit would be computed on a statewide, carrier-wide or other appropriate geographic area basis (as determined by the Secretary) using charge data from the second previous payment calculation period. The 90th percentile limit would not be used before January 1, 1992 because the necessary data would not be available.

(2) The conference agreement includes the House provision with an amendment. The agreement requires the Secretary to conduct a biannual survey of a representative sample of direct sellers, wholesalers, or pharmacists (as appropriate) to determine the applicable average wholesale price or comparable direct price for each single source drug as of the first day of the first month of the previous payment calculation period. The Secretary would be prohibited from taking into account any discounts that might be provided by wholesalers or direct sellers to pharmacies in determining the applicable average wholesale or direct prices.

Because the survey is a necessary part of the drug benefit and is vital to ensuring the integrity of reimbursement limits, the conference agreement permits the Secretary to impose civil money penalties of up to $10,000 if a wholesaler or direct seller refuses, after a request by the Secretary, to provide information required for the survey or provides information that is false. The conference agreement also requires pharmacies to cooperate with the survey and provides penalties for non-compliance. (*See* subparagraph (g), below.) Information gathered pursuant to the survey would be confidential and could not be disclosed by the Secretary, except as the Secretary determines to be necessary to administer the drug benefit.

The Secretary would not be required to conduct a survey with respect to a specific drug if the Secretary determines that such a survey would not be appropriate because of low volume of sales or other appropriate reason. The survey requirement could also be waived for covered outpatient drugs dispensed during 1990. In these circumstances, the Secretary would rely on published average wholesale prices from reliable sources and would have the authority to set the average wholesale price on the basis of the lowest reliable published price.

The agreement specifies that the Secretary shall make the determination of the average wholesale price based on the price or prices of purchases in reasonable quantities. The Secretary is further required to make the determinations and calculate the payment limit on a national basis. However, the Secretary could make such determinations on a regional basis to take into account limitations on the availability of drug products and variations in average wholesale prices among regions.

(3) The conference agreement includes the Senate amendment with an amendment. In the case of telephone prescriptions, a drug would only be subject to a restrictive prescription if the physician (or other person) through use of an appropriate phrase (as required for written prescriptions) states that a particular brand must be dispensed and submits a written confirmation to the pharmacy involved within thirty days after the date of the telephone prescription. If such confirmation is not submitted, payment would be based on limits for the corresponding multiple source drug.

(h) *Payment Limit For Multiple Source Drugs Without Restrictive Prescriptions.*—

(1) The conference agreement includes the Senate amendment with an amendment. The payment limit for a multiple source drug without a restrictive prescription is the sum of: (A) the product of the number of dosage units or tablet units dispensed and the unweighted median of the per unit average wholesale prices of the available drug products plus (B) an administrative allowance.

To determine the median, the Secretary would array the average wholesale prices (by appropriate dosage or tablet unit) for all FDA approved drug products that are rated by the FDA as therapeutically equivalent, including the corresponding brand name drug. (*See* subparagraph (3), below.

(2) The conference agreement includes the Senate amendment with a modification. In calculating the unweighted median, the Secretary is generally expected to use the average wholesale price for multiple source drugs based on reliable published sources. However, where appropriate, the Secretary may conduct a biannual survey of average wholesale prices of specific multiple source drugs. Such a survey is comparable to (and could be conducted in conjunction with) the annual survey of such prices for single source drugs. The conferees intend that the Secretary may exclude a drug from the calculation of the median if it is not being actively marketed.

(3) The conference agreement includes the House provision with an amendment. The agreement provides that in order for drugs to be multiple source drugs, the FDA must determine that they are pharmaceutically equivalent and bioequivalent as defined by the Medicare statute. This definition is the same as that currently used by the FDA. The agreement assumes that such FDA determination would be made at the time FDA approves the drug; it does not require a new or subsequent determination.

If the FDA changes the definition of therapeutic equivalence through a formal rule-making procedure (including a 90 day comment period), the requirement of pharmaceutical equivalence and bioequivalence as contained in the Medicare statute would not apply and the drug would only be required to meet the revised FDA definition of therapeutic equivalence.

(4) The conference agreement does not include the House provision.

(i) *Administrative Allowance.*—The conference agreement includes the Senate amendment with an amendment setting the ad-

ministrative allowance for participating pharmacies at $4.50 in 1990 and 1991 and for nonparticipating pharmacies at $2.50 in 1990 and 1991. Thereafter, the allowances are indexed by the GNP price deflator.

(J) *Assuring Appropriate Utilization.*—

(1) The conference agreement includes the Senate amendment with modifications. The agreement does not include the provision authorizing the Secretary to deny payment for drugs prescribed or dispensed with excessive frequency or in excessive quantities. The conferees note that such new authority is unnecessary. The Secretary already has authority under Section 1862(a)(1) of the Social Security Act to deny payment for items and services that are not reasonable and necessary for the diagnosis or treatment of illness or injury. Pursuant to this authority, the Secretary could deny payment for drugs prescribed or dispensed with excessive frequency or in excessive quantities.

The conference agreement requires the Secretary to establish a program to identify: (i) instances and patterns of unnecessary or inappropriate prescribing or dispensing practices; (ii) instances or patterns of substandard care; and (iii) potential adverse drug reactions.

The conferees expect that participating pharmacists will review the medication profile of beneficiaries for potential adverse reactions before filling prescriptions. The conferees further intend that carriers will review claims retrospectively to identify practitioners exhibiting a pattern of inappropriate drug prescribing or dispensing.

The conference agreement also requires the Secretary to establish an educational program to educate physicians and pharmacists about inappropriate prescribing and dispensing practices. This program is expected to include a range of educational interventions, ranging from written to face-to-face communications.

(2) The conference agreement includes the Senate amendment with modifications.

The conference agreement does not include the Senate provision which would have required the use of diagnosis codes on all prescriptions. The conferees believe this requirement would have been unduly burdensome for physicians. Instead, the conference agreement requires physicians to report the appropriate diagnosis code (or codes) on all claims for services they provide. This information would be available for immediate use for utilization review of physician services (and could be used for prepayment screens) and could be used in the future to facilitate drug utilization review by merging Part B with drug claims data.

To enforce the requirement of submission of diagnosis codes, the Secretary would be authorized to deny payment on assigned claims if the required diagnostic information is not provided. In the case of non-assigned claims, if a physician knowingly and willfully fails to respond to a request by a carrier to provide required information not initially included, the physician could be subject to civil money penalties of up to $2,000. Moreover, if a physician knowingly and willfully continues not to provide the required diagnostic information on the initial claims after being notified of the specific obliga-

tion to provide such information, the physician could be subject to civil monetary penalties and or exclusion from Medicare under Section 1842(j)(2)(A) of the Social Security Act.

The conferees intend that the Secretary will take appropriate measures to insure the confidentiality of patient-specific information which has been obtained.

The conference agreement includes the Senate provision on drug utilization review standards with modifications. The Secretary would be required to establish standards for the use of each covered outpatient drug based on accepted medical practice. In establishing these standards, the Secretary would be required to incorporate standards from one (or more) current authoritative compendia as the Secretary may select.

The conferees expect that included among the compendia the Secretary will consider for use are the United States Pharmacopoeia Dispensing Information, volume 1 (Drug Information for the Health Care Professional), the American Medical Association's Drug Evaluations, and American Hospital Formulary Service Drug Information. The conferees expect that the Secretary will use only those compendia which base such standards on a review of published scientific and medical information, which provide for a public comment and review process, and which provide adequate assurances that the panelists who establish standards are free of financial (or other) conflicts of interest.

The Secretary, through rule-making, may modify these standards, for use in the Medicare program, on the basis of published scientific and medical information indicating that such standards are not consistent with the safe and effective use of such drug.

The conference agreement also specifies that nothing in Title XVIII of the Social Security Act should be construed as authorizing the Secretary to establish a formulary by excluding from coverage: (i) any specific covered outpatient drug or class of drugs or (ii) the specific use of any covered outpatient drug with respect to a specific indication, unless the exclusion is pursuant to Section 1862(a)(1) and is based on a finding by the Secretary that such use is not safe or effective. The Secretary could, however, exclude certain drugs pursuant to Section 1862(c), relating to exclusions for drugs subject to a proposed order by the FDA to withdraw marketing approval, or 1861(t)(4)(A), relating to the definition of covered home IV therapy drugs (*See* subparagraph (b), above).

(k) *Treatment of Certain Prepaid Organizations.*—The conference agreement does not include the House provision or the Senate amendment. (*See* subparagraph (q), below.)

(1) *Physician Guide.*—The conference agreement includes the Senate amendment with a clarification. The Secretary is required to mail the guide by January 1 of each year, beginning in 1991, to participating hospitals, to each physician who routinely provides Part B services, to Social Security offices, to senior citizen centers, and to other appropriate places.

(m) *Special Cost Control Measures.*—The conference agreement includes the Senate amendment with a modification. The agreement requires the Secretary, immediately upon enactment, to begin compiling information on prices charged by manufacturers and by retail pharmacies for covered outpatient drugs. The Secre-

tary shall compare increases in drug prices for each six month period beginning January 1, 1987, with the average semi-annual increase in such prices during the January 1, 1981 to January 1, 1987 period. The agreement also requires the Secretary to review all available information on the use of prescription drugs by Medicare beneficiaries. The conference agreement requires the Secretary to file a report with the House Committees on Ways and Means and Energy and Commerce and the Senate Committee on Finance in May and November of 1989 and 1990 and in May of each succeeding year containing this information.

Each report submitted after 1991 will also include an explanation of the extent to which increases in expenditures for covered outpatient drugs are the result of price increases by manufacturers and pharmacists and increased drug use by beneficiaries and will include information: (i) on the projected budgetary status of the prescription drug trust fund for the succeeding year; (ii) projected increases in manufacturer's and pharmacists' prices; (iii) the projected level of utilization of covered outpatient drugs by beneficiaries; and (iv) projected administrative costs.

The conference agreement requires the Secretary to submit monthly reports to the Congress, from October 1991 through April 1993, showing monthly outlays and receipts of the Federal Catastrophic Drug Insurance Trust Fund.

The agreement further specifies that the Secretary's May 1, 1992 and 1993 reports will determine whether the anticipated outlays and receipts of the new trust fund are sufficient to achieve the established contingency reserve margin for 1993 and 1994. If not, the report will recommend necessary changes (which will also be published in the Federal Register by May 1 as a proposed regulation). Any such recommended changes should appropriately address each of the causes of increased or unanticipated costs for the program.

If the Secretary has published a proposed regulation by May 1 of 1992 or 1993, the Secretary may publish a final regulation during the last 3 days of September of such year to implement the changes proposed. Such changes will become effective as of January 1 of the next year and will apply only during such year and will take effect notwithstanding any other provisions of this part.

Several limitations, however, would apply to the Secretary's cost control authority. First, the final regulation may not provide for a net reduction in outlays in excess of the net reduction provided in the proposed regulation. Second, the Secretary may not provide for a formulary in violation of the prohibition contained in subparagraph (j). Third, the Secretary may not change the methodology for calculating whether the drug deductible has been met (but could change the level of the deductible). Finally, the Secretary could not increase the coinsurance above the level in effect during the previous year.

The conferees intend that, in designing any cost control recommendations, the Secretary will attempt to insure that beneficiary access will not be adversely affected.

The conferees expect and encourage the Secretary to make other recommendations concerning legislative changes that would improve the administration of the new outpatient prescription drug

benefit. Such recommendations would be subject to approval by the Congress as part of the normal legislative process.

The conferees understand that the proposed and final regulations will not be reflected in the Congressional Budget Office's August baseline for FY 1993 and FY 1994.

(n) *High Volume Pharmacies.*—The conference agreement includes the Senate amendment with a modification limiting the Secretary's authority to reducing the administrative allowance for mail service pharmacies. Such reductions (if any) must be based on differences between mail service pharmacies and other pharmacies with respect to operating costs and other economies.

(o) *Report on Payment Limits.*—The conference agreement deletes this provision. The conferees intend to request, by letter, the Office of Technology Assessment to prepare a study on possible alternative payment methodologies.

(p) *Report on Covered Outpatient Drug Index.*—The conference agreement does not include the House provision.

(q) *Participating Pharmacies.*—

(1)(A).—The conference agreement includes the Senate amendment. The conferees note that some prepaid health plans operate pharmacies which charge members of the plan less than the pharmacy charges members of the general public. In this case, the conferees intend that the test of compliance with this provision be based on the pharmacy's charges to members of the general public who are not members of the prepaid health plan.

(1)(B).—The conference agreement includes the House provision.

(1)(C).—The conference agreement includes the House provision with a modification. The Secretary would be required by January 1, 1991 to establish an electronic point-of-sale claims processing system for use by carriers and participating pharmacies. Participating pharmacies would be required to transmit information regarding all covered outpatient drugs dispensed to Medicare beneficiaries by such pharmacies regardless of deductible status.

The conferees consider the electronic billing system integral to the smooth administration of the prescription drug benefit. The conferees expect that the Secretary will devote the necessary resources to make the electronic system fully and successfully operational by January 1, 1991. Moreover, the conferees expect that the system will be thoroughly tested prior to that date.

(1)(D).—The conference agreement does not include the House or Senate provision.

(1)(E).—The conference agreement includes the Senate amendment.

(1)(F).—The conference agreement includes the Senate amendment.

(1)(G).—The conference agreement includes the Senate amendment with an amendment deleting the exemption for undue hardship. As noted above, the agreement requires the Secretary to implement an electronic point-of-sale system by January 1, 1991. The agreement further requires the Secretary to provide, upon request, such electronic equipment and techni-

cal assistance (other than costs associated with obtaining, maintaining, or expanding telephone service) as the Secretary determines may be necessary for a pharmacy to submit claims through the electronic system. Because the equipment would be provided where necessary an exemption for hardship cases is not needed.

The conference agreement requires participating pharmacies to provide information requested by the Secretary in conjunction with biannual surveys conducted by the Secretary to determine average wholesale prices. (see Item 10g).

All of the preceding requirements for participating pharmacies would be first effective for covered outpatient drugs dispensed on or after January 1, 1991. Claims for drugs dispensed during 1990 would be handled by existing Medicare carriers and the beneficiary's deductible status would be determined by these carriers as under current law.

The Secretary would have authority to specify claims processing and payment procedures in the event of temporary failure of the electronic claims processing system.

(2).—The conference agreement includes the Senate amendment with an amendment deleting the requirement that the Secretary submit lists of payment limit to pharmacies in advance of the payment calculation period.

(3).—The conference agreement includes the Senate amendment with a modification. The agreement provides that the audits would assure compliance with requirements for participation and would assure the accuracy of information submitted by pharmacies.

(4).—The conference agreement includes the Senate amendment with an amendment clarifying that the requirement to accept assignment begins at the point where the Secretary, through the electronic point-of-sale system or otherwise, notifies the pharmacy that the beneficiary has met the deductible.

(r) *Civil Monetary Penalty.*—The conference agreement includes the Senate amendment authorizing civil monetary penalties for pharmacies that charge Medicare beneficiaries more than they charge the general public. For purposes of this provision, the price charged to the general public is the pharmacy's price to a customer who is not a member of any group which has obtained a discounted price from that pharmacy, such as an HMO.

The conference agreement also authorizes civil monetary penalties for pharmacies that fail to provide information requested by the Secretary as part of the biannual survey of wholesale prices (see Item 10g).

(s) *Limitation to 60 Day Prescription.*—The conference agreement includes the Senate amendment with an amendment. No payment may be made for any expense incurred for a covered outpatient drug if it is dispensed in a quantity exceeding a 30 day supply, except that the Secretary may authorize a longer supply (not exceeding 90 days, except in exceptional circumstances). Such extended supply policies may apply to specific drugs or classes of drugs and may be subject to appropriate conditions as the Secretary may establish.

(t) *Additional Premium for Prescription Drug Benefit.*—See Item No. 15.

(u) *Use of Carriers in Administration.*—

(1) The conference agreement includes the Senate amendment with modifications.

Current law requires that a Medicare carrier be an insurer of health care services. The conference agreement waives this requirement and authorizes the Secretary to contract with other entities for implementation and operation of the electronic point-of-sale claims processing system and for related functions. Such entities include voluntary associations, corporations, partnerships, or other nongovernmental organizations. Such contracts may be on a regional basis.

If the Secretary requires a carrier to subcontract with such an entity for this purpose, the conferees expect the Secretary to take this arrangement into account in evaluating the carrier's performance. The failure of such entity to properly carry out its responsibilities should not adversely affect the carrier's performance rating.

The conferees further intend that the term "related functions" would apply to functions closely related to the implementation and operation of the electronic system, such as initial claims denials made through the system. Other functions, such as the handling of beneficiary inquiries and carrier fair hearings, would remain with the traditional Medicare carriers.

The agreement permits the Secretary to use fixed-price contracts for electronic claims processing (and related functions) but requires the Secretary to: (i) publish in the Federal Register general criteria and standards used for evaluating contractors and provide opportunity for public comment; (ii) publish in the Federal Register any new policy or procedure that substantially affects the performance of contracts 30 days before such policy or procedure is to take effect; and (iii) negotiate necessary contractual modifications with contractors before requiring them to perform any additional functions.

The conferees expect that the Secretary would initially contract with more than one entity to establish more than one electronic system.

The agreement specifies that current law requirements regarding coordination of benefits payments with Medicare supplemental insurers will not apply to covered outpatient drugs until January 1, 1993.

(2) The conference agreement includes the Senate amendment with a modification. The agreement requires contractors processing claims for prescription drugs to provide for a monthly payment cycle. All claims received and approved for each participating pharmacy or individual submitting claims in the period since the previous payment date would be paid at the end of the payment cycle.

The conferees understand that under this system, claims would be paid, on average, 15 days after receipt. If payment is delayed more than 5 days after the requisite payment date, interest shall accrue until payment is made.

(3) The conference agreement includes the Senate amendment.

(v) *Modification of HMO/CMP Provisions.*—

(1) The conference agreement does not include the House provision or the Senate amendment.

(2) The conference agreement includes the Senate amendment.

(3) The conference agreement includes the Senate amendment.

(w) *Medicaid Requirements.*—See Item No. 33.

(x) *Beneficiary Drug Cost Survey and CBO Report.*—

(1) The conference agreement includes the Senate amendment with a modification. Data obtained from the 1987 National medical Expenditure Survey (NMES) would be used in lieu of conducting a new survey. Based on this data, the Secretary would submit a report on expenses incurred by Medicare beneficiaries for outpatient drugs to Congress by April 1, 1989. Also by this date, the Secretary would provide the Director of the Congressional Budget Office any data from the survey that the Director may request to make the estimates required under subparagraph (2) below.

(2) The conference agreement includes the Senate amendment with an amendment specifying the CBO report is due by June 1, 1989, or 60 days after the date the Secretary provides the requested data under subparagraph (1). The report is to include estimated outlays and revenues (with projected trust fund balances) for the period from FY 1990 through FY 1993.

(3) The conference agreement does not include the Senate amendment.

(y) *Prescription Drug Payment Review Commission.*—The conference agreement includes the House provision with an amendment. The Commission is to be established by January 1, 1989. The conferees expect that one of the eleven commissioners would be associated with a brand name drug manufacturer while another would be associated with a generic drug manufacturer.

The Commission is directed to submit an annual report to Congress by May 1 of each year, beginning May 1, 1990. The report would concern methods of determining payment for the outpatient prescription drug benefit authorized under this legislation. Beginning in 1992, the annual report must include comments on both the budgetary status of the Federal Catastrophic Drug Insurance Trust Fund and recommendations for any changes necessary to reduce outlays in order to achieve the established contingency margin for the following year. These recommendations are to take into account the causes of increased or unanticipated outlays for covered drugs in the year.

Beginning in 1992, the annual report would also include information on increases in manufacturers' prices for prescription drugs, increases in pharmacies' charges for such drugs, utilization of the outpatient prescription drug benefit by beneficiaries, and administrative costs associated with the benefit.

(z) *Additional Studies.*—The conference agreement includes the Senate amendment with modifications. The requirement for a report on third party coverage is not included. The conferees note

that under subparagraph (x) the Secretary is required to conduct a study of drug expenditures by the elderly. It is expected that the issue of third party coverage will be addressed in that study.

The conference agreement provides for a one-time study by the GAO which would include: (i) a comparison of average wholesale drug prices and actual acquisition costs by type of pharmacy; (ii) an analysis of the discounts offered by pharmacies to other third-party insurers; and (iii) an analysis of overhead costs of retail pharmacies. The study would be due to Congress by May 1, 1991.

Pharmacies participating in Medicare or Medicaid would be required to provide the GAO with reasonable access to records needed to conduct the study; non-compliance would be subject to exclusion from Medicare or Medicaid under Section 1128(a) of the Social Security Act. The conferees expect that the GAO would not release any data from the study in a manner which could be identified with individual pharmacies.

The conference agreement does not include a requirement for a study on the potential application of new claims processing and billing technologies. The conferees note that the agreement requires the Secretary to implement an electronic point-of-sale claims processing system.

The conference agreement requires a study of methods to improve utilization review of covered outpatient drugs. The study is due to the Congress by January 1, 1993.

The conference agreement does not include the requirement that the Secretary study alternative payment methodologies for covered outpatient drugs. The conferees note that under subparagraph (o) above, the conferees intend to request the Office of Technology Assessment to conduct a similar study.

The conference agreement also does not include the study on induced demand. The conferees expect that this issue will be addressed in the study required under subparagraph (x).

The conference agreement specifies that the longitudinal study of the use of covered outpatient drugs by Medicare beneficiaries is to be conducted as a follow-up to the 1987 NMES study. The report is due January 1, 1993.

The conference agreement expands the scope of the requisite study on experimental cancer drugs to include other experimental drugs and biologicals. This report is due January 1, 1990.

The conference agreement also requires the Secretary to study the potential of mail service pharmacies to reduce the cost of covered outpatient drugs for beneficiaries and for the Medicare program and to report to Congress by January 1, 1990.

(aa) *Study of the Treatment of Prescription Drugs.*—The conference agreement does not include the Senate amemdment.

(bb) *Simplification of Recordkeeping.*—The conference agreement includes the Senate amendment with modifications. The agreement requires the Secretary to develop a standard claims form and a standard format for electronically submitted claims to be used by Medicare and other third parties for covered outpatient drugs. The Secretary would consult with representatives of pharmacies and other interested individuals in developing these standards. The Secretary would be required to distribute official sample copies by October 1, 1989.

The conference agreement does not include the requirement for demonstration projects testing various electronic billing systems. The conferees note that the Secretary is required to implement a point-of-sale electronic claims processing system.

Effective Date.—Applies to items dispensed on or after January 1, 1990, except for the following.

Prompt payment requirements for carriers take effect on January 1, 1991, but are not to be construed as requiring payment before February 1, 1991, thereby permitting implementation of staggered billing cycles.

Provisions relating to modification of HMO/CMP contracts apply to new enrollments effective on or after January 1, 1990.

Diagnostic coding requirements apply to services furnished on or after April 1, 1989.

11. Coverage of Home Intravenous Drug Therapy (Section 7A of Senate amendment)

Present Law

(a) General.—Drugs and biologicals, which cannot be self-administered and which are furnished as an incident to a physician's professional service, are included within the definition of "medical and other health services," and are covered under Part B. Such coverage also includes antigens prepared by a physician and administered by or under the supervision of a physician.

(b) Payment.—No provision.

(c) Certification.—Except for certain inpatient or outpatient services provided by hospitals, payments for services to providers under Part B may only be made if a physician certifies (and recertifies where such services are furnished over an extended period) that the services are necessary.

(d) Certification of Providers.—The Secretary, in carrying out his functions related to determination of conditions of participation of providers of services, shall consult with appropriate national listing and accreditation bodies, and may consult with appropriate local agencies. If a State imposes higher requirements on institutions as a condition of payment under titles I, XVI, or XIX (Medicaid) of the Social Security Act, the Secretary shall impose like requirements under Medicare.

(e) Intermediate Sanctions for Home Intravenous Drug Therapy Providers.—No provision.

(f) Publication Requirement.—No provision.

House bill

No provision.

Senate amendment

(a) General.—Provides for Medicare coverage of intravenous drug therapies provided in the home. Home intravenous therapy is defined as items and services that: (1) are provided to an individual who is under the care of a physician; (2) are provided in the residence used as the individual's home; (3) are provided by a qualified home intravenous drug therapy provider or by others under ar-

rangement with such provider; and (4) are provided under a plan established and periodically reviewed by a physician.

Coverage for home intravenous drug therapy includes nursing, pharmacy and related services as are necessary to safely and effectively conduct an intravenously administered anti-infective or cancer chemotherapeutic drug regimen through the use of a covered outpatient drug or use of any other intravenously administered drug which the Secretary (in consultation with providers, clinicians and consumers) determines may be safely provided in the home.

A qualified home intravenous drug therapy provider is defined as a home health agency certified by the Secretary as meeting certain conditions of particpation, or other entity certified by the Secretary as meeting certain conditions of participation. The conditions of participation require that the home health agency or other entity: (1) is capable of providing or arranging for the provision of home intravenous drug therapy; (2) maintains clinical records; (3) has written policies to govern the provision of services; (4) makes services available 24 hours per day, seven days a week as necessary; (5) coordinates all services with the patient's physician; (6) conducts a quality assessment and assurance program, including drug regimen review and coordination of patient care; (7) assures that only trained personnel provide chemotherapy or any other service where training is required to safely provide the service; (8) assumes responsibility for the quality of services provided by others under arrangements; and (9) meets such other conditions as the Secretary determines are necessary for the safe and effective provision of services and as necessary for the efficient administration of the benefit.

(b) Payment.—Requires the Secretary to establish a fee schedule for home intravenous drug therapy prior to the beginning of each calendar year, beginning prior to calendar year 1990. The fee schedule is to be established on a per diem basis. The fee schedule is to be based on a study of current reimbursement for similar items and services provided under Medicare, on the customary charges for such therapy, and on such other information as the Secretary deems appropriate.

Reimbursement for home intravenous drug therapy is 100 percent of the lesser of the actual charge and the fee schedule amount. Payments for these items and services is not subject to the annual Part B deductible amount.

(c) Certification.—Provides that coverage for home intravenous drug therapy is limited to cases in which a physician certifies that (1) such therapy is required by the individual, (2) a plan for furnishing the therapy has been established and is periodically reviewed by a physician, (3) the therapy is furnished while the individual is under the care of a physician, and (4) the therapy is provided in a place of residence used as the individual's home.

(d) Certification of Providers.—Adds home intravenous drug therapy providers to the list of providers for which the Secretary shall consult with appropriate State agencies and recognized national listing or accrediting bodies, and appropriate local agencies in determining the conditions of participation.

(e) Intermediate Sanctions for Home Intravenous Drug Therapy Providers.—Provides that the Secretary shall develop and implement "intermediate sanctions," in lieu of canceling the certification of the provider, that may be imposed for a period of up to one year against home intravenous drug therapy providers that are determined by the Secretary to no longer meet the conditions of participation. The Secretary shall provide appropriate appeals procedures relating to the imposition of such intermediate sanctions. The intermediate sanctions shall include civil money penalties and suspension of all or part of reimbursement amounts that would otherwise be made under Medicare. Such sanctions are in addition to sanctions otherwise available under State or Federal law.

The Secretary shall develop and implement specific procedures with respect to when and how each of the intermediate sanctions may be imposed, the amount of any fines and the severity of each penalty. The procedures are to be designed to minimize the time between the identification of violations and imposition of the sanction, and shall provide for the imposition of increasingly severe fines for repeated or uncorrected deficiencies.

(f) Publication Requirement.—Provides that the Secretary shall publish a list of categories of drugs that are considered covered outpatient drugs with respect to home intravenous drug therapy not later than January 1, 1990.

Effective date.—Applies to items and services furnished on or after January 1, 1990

Conference agreement

(a) *General.*—The conference agreement includes the Senate amendment with amendments.

Covered home IV drug therapy services include nursing, pharmacy, and related items and services (such as medical supplies, IV fluids, delivery, and equipment) as are necessary for the safe and effective administration of covered home IV drugs. Drug therapy services would not be subject to the Part B deductible or to coinsurance.

Drugs used for home IV drug therapy are not included in the definition of covered home IV drug therapy services, and are not included in the reimbursement for these services. Instead, these drugs are covered and reimbursed under the catastrophic prescription drug benefit. (See Item 10 concerning coverage of IV drugs).

A qualified home IV drug therapy provider must comply with requirements contained in the Senate provision. The conference agreement adds the requirement that the provider must adhere to written protocols with respect to provision of services and expands the requirement pertaining to use of trained personnel to cover provision of all home IV drugs. Further, the entity must be licensed, or approved as meeting the requirements for licensure, if State or local law provides for licensure of home IV drug providers.

A home health agency may qualify as a home IV drug therapy provider if it meets these requirements. In this case, the home health agency would not have to be recertified with respect to any conditions that it had previously met to be certified as a home health agency.

(b) *Payment.*—The conference agreement includes the Senate amendment with amendments. Under the agreement, Medicare payment would be the lower of the provider's actual charge or the fee schedule amount.

The fee schedule would be established by the Secretary by regulation before January 1, 1990 and would provide payment on a per diem basis. In establishing the fee schedule, the Secretary could consider cost information, charge information, and payment rates for similar items and services covered under Medicare. The Secretary could not, however, require routine cost reporting.

The conference agreement provides the Secretary with broad flexibility in establishing the fee schedule. The conferees expect that the Secretary will use this flexibility to establish a fee schedule which assures adequate access to services while preventing excessive payments. The conferees note that exclusive reliance on customary charges has previously resulted in excessive reimbursement levels for similar services.

The conferees expect that the availability of home IV therapy will facilitate shorter hospital lengths of stay for a variety of illnesses. The conference agreement therefore requires the Prospective Payment Assessment Commission to study and report to the Congress and the Secretary by March 1, 1991 concerning adjustments to DRG payments which may be appropriate in view of the expected savings to hospitals.

Finally, the conference agreement prohibits a home IV therapy provider from providing services to a Medicare beneficiary based on a referral from a physician who has an ownership interest in, or receives compensation from, the provider. The prohibition would also apply to ownership or compensation arrangements involving an immediate family member of the referring physician. The referring physician is the physician who prescribes the home IV drug therapy or establishes the plan of care for such therapy.

Several exceptions to this prohibition are provided: (i) ownership of publicly traded stock purchased on terms available to the general public; (ii) sole community rural home IV therapy providers as defined by the Secretary; (iii) compensation reasonably related to items or services actually provided by the physician which does not vary in proportion to the number of referrals made; (iv) physicians whose only relationship with the provider is as an uncompensated officer or director of the provider; and (v) other exceptions established by the Secretary by regulation, for ownership or compensation arrangements which the Secretary determines do not pose a substantial risk of program abuse. The exception under clause (iii) would not apply for compensation paid by the home IV provider to the referring physician for direct patient care services. It is expected that the physician would bill Medicare (or the beneficiary) for such services.

Payment would be denied for services provided pursuant to a prohibited referral. The home IV provider would also be prohibited from billing for such services on an unassigned basis. Moreover, a physician who knowingly and willfully makes a prohibited referral or a provider who knowingly and willfully accepts such a referral would subject to civil monetary penalties of up to $15,000 for each such referral and/or exclusion from the Medicare program.

The conferees intend that this prohibition not be construed in any way as altering (or reflecting on) the scope and application of the anti-kickback provisions contained in Section 1128B of the Social Security Act.

The conferees are aware of the growing prevalence of physician ownership and compensation arrangements which are developed and marketed by providers of medical services. These arrangements are often initiated with the intent of binding together the financial interests of referring physicians with those of the providers.

Because of the resulting economic alliance, physicians are less likely to exercise independent judgment in making referral recommendations. Moreover, such alliances pose a risk of inducing over utilization even if the physician's income does not vary in proportion to the number of referrals made.

Some of these arrangements may involve indirect referral fees. Investment opportunities may be restricted to physicians who are able refer substantial business to the provider, and such investments often have returns which are substantially higher than what would be expected for comparable investments.

For these reasons, the conference agreement includes a requirement that the HHS Inspector General conduct a study of physician owneship of, and compensation by, other suppliers of Medicare covered services to which they make referrals. The report would (i) include a description of the full range of such arrangements and the means by which they are marketed to physicians; (ii) evaluate the potential of such arrangements to influence physician decisionmaking and to result in inappropriate utilization; (iii) assess the practical difficulties involved in enforcement actions under current anti-kickback provisions; and (iv) make recommendations regarding possible changes in the law to strengthen protections against program abuse. The report would be due to Congress by May 1, 1989.

(c) *Certification.*—The conference agreement includes the Senate amendment with an amendment.

The conference agreement requires that all home IV therapy services be reviewed and approved for medical necessity and quality by a Peer Review Organization (PROs) during a three-year period (1990–1992).

Prior approval by a PRO is required for home IV therapy initiated immediately upon hospital discharge. Except in exceptional circumstances (specified by the Secretary), home IV therapy services initiated on an outpatient basis (without a preceding hospital stay) must be approved by the PRO within one working day after the initiation of therapy. PROs would be required to complete reviews within one working day of receipt of a request for review.

To assure the validity and uniformity of PRO reviews, the conference agreement requires the Secretary to establish criteria that would be used by PROs in conducting reviews with respect to the appropriateness of home IV therapy services. Such criteria should assure that beneficiaries are discharged from hospitals to home IV therapy only if this is appropriate from a medical standpoint and the patient (or a family member) is able to carry out the home care regimen properly.

The conferees expect that after 1982, the Secretary could require PROs to conduct some focused reviews and could require prior approval in appropriate circumstances.

(d) *Certification of Providers.*—The conference agreement includes the Senate amendment with a clarifying amendment specifying that a home IV drug therapy provider is a "provider" of services as defined under Medicare.

The conference agreement further requires the Secretary, in consultation with State agencies and other organizations to develop conditions of participation for home IV drug theraphy providers.

(e) *Intermediate Sanctions for Home Intravenous Drug Therapy Providers.*—The conference agreement includes the Senate amendment.

(f) *Publication Requirement.*—The conference agreement includes the Senate amendment.

Effective date.—Applies to services furnished on or after January 1, 1990.

12. In-Home Care for Certain Chronically Dependent Individuals (Section 203 of House bill)

Present law

No provision.

House bill

(a) Services Covered.—Adds a new benefit to Part B of Medicare: in-home care for a chronically dependent individual for up to 80 hours in any calendar year. [Such care provided on any day for 3 hours or less is counted as 3 hours.]

Defines "in-home care" as including (1) services of a homemaker/home health aide (who has successfully completed a training program approved by the Secretary); (2) personal care services; and (3) nursing care provided by a licensed professional nurse. Requires that these services be furnished, under the supervision of a registered professional nurse, by a home health agency or others under arrangements with the agency. Also requires that the services be furnished in a place of residence used as the chronically dependent individual's home.

(b) Persons Eligible.—Provides that the above services be available to chronically dependent individuals who are Medicare beneficiaries. Defines "chronically dependent individual" as a person who (1) is dependent on a daily basis on a primary caregiver who is living with the individual and is assisting the individual without monetary compensation in the performance of at least 2 specified activities of daily living (ADLs); and (2) without this assistance could not perform these ADLs. Specifies that the individual be dependent in at least 2 of the following ADLs: eating, bathing, dressing, toileting, or transferring in and out of a bed or in and out of a chair.

(c) Payment.—Provides that payment for in-home services be made on the basis of hourly rates based on reasonable costs of furnishing care.

Requires the Secretary to provide for an appropriate adjustment to payment rates for prepaid health plans paid on a reasonable cost

basis to reflect the new catastrophic protection. The adjustment is to reflect: (1) the aggregate increase in payments which would otherwise be made for enrollees if they were not enrolled in the organization; or (2) the amount that would be paid to the organization or facility if payments were made on an individual by individual basis. The organization is required to provide assurances, satisfactory to the Secretary, that it will not undertake to charge an individual more than 20 percent of reasonable costs plus any deductible amounts.

(d) Certification.—Requires a physician to certify, in the case of in-home services provided to a chronically dependent individual during a 12-month period, that the individual was chronically dependent during the immediately preceding 3-month period.

(e) Standards for Utilization.—Specifies that payment may not be made for in-home care for chronically dependent individuals unless such care is reasonable and necessary to assure the health and condition of the individual is maintained in the individual's non-institutional residence. The Secretary is required to take appropriate efforts to assure the quality and provide for the appropriate utilization of in-home care for chronically dependent individuals.

(f) Study of Alternative Out-of-Home Services.—Requires the Secretary to study and report to Congress, within 18 months of enactment, on the advisability of providing to chronically dependent individuals (eligible for services under this provision) with out-of-home services (such as adult day health services or nursing facility services) as an alternative to in-home care.

(g) Study of In-Home Care.—Requires the Secretary to study and report to Congress by June 1, 1991, on the extent of use, cost, and effectiveness of in-home care provided chronically dependent individuals under this provision. [See also item 25]

Effective date.—(a) through (e) apply to items and services furnished on or after January 1, 1989, and before January 1, 1992. Study provisions (f) and (g) effective on enactment.

Senate amendment

No provision.

Conference agreement

(a) *Services Covered.*—The conference agreement includes the House provision, with the amendment noted below regarding the 12 month period of eligibility for the services.

(b) *Persons Eligible.*—The conference agreement includes the House provision, with an amendment. It retains the definition of chronically dependent individual. However, such an individual qualifies for these services only if the individual has been determined either: (i) to have incurred expenses for Part B coinsurance and deductible payments in an amount equal to the catastrophic limit on Part B cost-sharing for the year; or (ii) to have incurred expenses for covered outpatient drugs equal to the outpatient drug deductible for the year. In-home services would then be available to such a beneficiary for 12 months from the date the beneficiary was determined by the Medicare carrier to have incurred such expenses.

If a beneficiary met a second limit within twelve months after meeting a prior limit, this would initiate a new twelve month period of eligibility. In this situation, the beneficiary would be entitled to receive up to 80 hours of care during the new eligibility period, but could not carry over any hours not used during the prior eligibility period. Moreover, in no event could a beneficiary receive more than 80 hours of care during a calendar year.

An individual receiving these services would be responsible for 20 percent coinsurance, notwithstanding that he or she had already met the Part B catastrophic limit in the current year. However, these coinsurance payments could be counted towards the catastrophic limit, during the calendar year in which they were incurred.

The Secretary would be required to take appropriate measures to assure that HMO members who would otherwise qualify for this benefit are properly identified.

(c) *Payment.*—The conference agreement includes the House provision.

(d) *Certification.*—The conference agreement includes the House provision.

(e) *Standards for Utilization.*—The conference agreement includes the House provision.

(f) *Study of Alternative Out-of-Home Services.*—The conference agreement includes the House provision.

(g) *Study of In-Home Care.*—The conference agreement does not include the House provision.

Effective Date.—The conference agreement applies to services furnished on or after January 1, 1990.

13. Extending Home Health Services (Section 204 of House bill; Sections 7 and 8 of Senate amendment)

Present law

(a) Intermittent/Daily Home Health Care.—Home health services are covered under Medicare if the services are required because the individual is homebound and requires skilled nursing care on an intermittent basis or physical or speech thereapy. Current program guidelines specify that to meet the requirement for intermittent skilled nursing care, an individual must have medically predicable recurring need for skilled nursing services. The guidelines define "intermittent" as permitting daily skilled nursing visits for up to eight hours a day for up to two or three weeks if medically reasonable and necessary. Daily is defined as five, six, or seven days per week.

(b) Homebound.—Comparable provision included in the Omnibus Budget Reconciliation Act of 1987, section 4024 of Public Law 100-203.

House bill

(a) Intermittent/Daily Home Health Care.—Specifies that nursing care and home health aide services are considered intermittent if they are furnished less than 7 days a week. These services may be provided 7 days a week for an initial period up to 35 consecutive days. More than 35 consecutive days may be covered if the physi-

cian certifies that exceptional circumstances require additional care on a daily basis.

Effective date.—(a) Applies to services furnished on or after January 1, 1989.

Senate amendment

(a) Intermittent/Daily Home Health Care.—Provides that nursing care and home health aide services may be provided 7 days a week (with one or more visits per day) for up to 21 days with a physician's certification of the need for such care. For a beneficiary enrolled in Part B, up to 45 days of consecutive care would be allowed if he was discharged from a hospital or skilled nursing home within 30 days prior to beginning home health care.

Effective date.—(a) Applies to items and services furnished after December 31, 1987.

Conference agreement

(a) *Intermittent/Daily Home Health Care.*—The conference agreement includes the Senate amendment with a modification. The agreement provides that nursing care and home health aide services may be provided 7 days a week (with one or more visits per day) for up to 38 consecutive days. The conferees intend that current coverage policies which allow for additional days of care under unusual circumstances would continue to be covered under Medicare.

The conference agreement further extends the favorable presumption under the waiver of liability provisions for skilled nursing facilities and home health agencies. The Secretary is prohibited from modifying the presumption criteria for these waivers through October 1990.

The conference agreement requires the Administrator of the Health Care Financing Administration to appoint an 11 member Advisory Committee on Home Health Claims. At least five members shall be representatives of home health agencies or visiting nurse associations. The remaining members are to be representative of physicians' groups, senior citizens' groups and fiscal intermediaries, with no more than 3 members representative of fiscal intermediaries. The advisory committee is to study the reasons for the increase in the denial rate for home health claims during 1986 and 1987, the ramifications of such increase, and the need to reform the process involved in such denials. A report on the committee's findings is due to the Health Care Financing Administration and to the Congress within one year of enactment.

(b) *Homebound.*—The conference agreement does not include the Senate provision. The conferees note that a comparable provision was included in the Omnibus Budget Reconciliation Act of 1987.

Effective date.—The conference agreement applies to home health services furnished on or after January 1, 1990.

14. Increase in Maximum Payment Allowed for Outpatient Mental Health Services (Section 205 of House bill)

Present law

A special limit is applicable with respect to expenses incurred in a calendar year in connection with the treatment of a mental, psychoneurotic or personality disorder of a beneficiary who is not an inpatient of a hospital at the time services are rendered. Medicare recognizes 62.5 percent of reasonable charges for such services. It pays 80 percent of the recognized amount up to a maximum of $250. The Omnibus Budget Reconciliation Act of 1987 increases the maximum payment amount to $450 in 1988 and $1,100 in 1989.

House bill

Increases the medicare outpatient mental health payment limit to $1,000.

A maximum of $250 in out-of-pocket expenses may be counted toward the catastrophic limit. The effective beneficiary coinsurance rate remains the same.

Effective date.—Applies to expenses incurred for services furnished on or after January 1, 1989.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision. The conferees note that a provision was included in Section 4070 of the Omnibus Budget Reconciliation Act of 1987 which increased the maximum payment amount for mental health services beyond that provided in this legislation.

15. Adjustments in Medicare Part B Premium (Section 206 of House bill; Sections 5 and 27 of Senate amendment)

Present law

(a) Part B Premiums.—Under current law, premiums for Medicare Part B are charged to Part B enrollees on a monthly basis according to an amount established in advance for each calendar year. The monthly Part B premium for 1988 is $24.80.

During September of each year, the Secretary determines the monthly actuarial rate for the succeeding calendar year for Part B enrollees age 65 and over equal to one-half of the benefits and administrative costs for aged Part B enrollees, including a contingency margin.

The Secretary also determines during September of each year the monthly actuarial rate for disabled enrollees under age 65 for the succeeding calendar year equal to one-half of the benefits and administrative costs estimated to be payable from the Part B trust fund for services and related administrative costs for disabled enrollees under age 65, including a contingency margin.

The current method of determining the monthly premium (temporarily in effect for 1984–89) is to use a formula that sets the premium rate at 50 percent of the monthly actuarial rate for enrollees

age 65 and over (i.e., 25 percent of the amount needed to cover program costs for aged beneficiaries). Disabled enrollees pay the same premium.

If there is no Social Security cost-of-living increase (COLA) in a year, the Part B premium is not increased that year. For 1986-89, a beneficiary who has his Part B premium deducted from his Social Security check and experiences a premium increase that is greater than the COLA adjustment, the premium increase is reduced to avoid a reduction in the individual's Social Security check.

Beginning January 1, 1990, the premium will be calculated according to prior law, which provided that the premium would be the lower of: (1) an amount sufficient to cover one-half of the costs of the program for the aged, or (2) the current premium amount increased by the Social Security COLA.

(b) Catastrophic Coverage Premium.—No provision.

(c) Premium for Prescription Drug Benefit.—No provision.

(d) Benefit Premium for In-Home Care Benefit.—No provision.

(e) Monthly Premiums for Residents of U.S. Commonwealths and Territories.—All Medicare beneficiaries voluntarily enrolled in Part B are subject to the same Part B premium payment rules and receive the same Medicare benefits, including those residing in the U.S. commonwealths and territories. An individual need not be entitled to Part A benefits to voluntarily enroll in Part B.

(f) Monthly Premiums for Individuals Enrolled Under Part B But Not Entitled to Benefits Under Part A.—All Medicare beneficiaries voluntarily enrolled in Part B are subject to the same Part B premium payment rules and receive the same Medicare benefits, including those not entitled to benefits under Part A.

(g) Transfers to Catastrophic Health Insurance Trust Fund.—No provision.

House bill

(a) In General.—Provides for increases to the monthly Part B premium to finance the catastrophic coverage benefit (through the transitional adjustment in 1991 and 1992), the prescription drug benefit (beginning in 1989), and the in-home care benefit (in 1989, 1990, and 1991.)

(b) Catastrophic Coverage Premium.—

(1) Premium Amount.—Provides for a transitional adjustment increase to the monthly Part B premium otherwise determined of $1.00 in 1991 and $1.30 in 1992.

(2) Indexing.—Provides that the transitional increase in 1991 will not be taken into account when determining Part B increases in subsequent years under section 1839(a)(3), but the transitional increase in 1992 will be taken into account when determining Part B increases in 1993 and each subsequent year.

(c) Premium for Prescription Drug Benefit.—Amends section 1839 (amount of the Part B premium) to provide for an additional monthly premium for the prescription drug benefit.

(1) Premium Amount.—Provides that the basic monthly drug premium increase for a year is, subject to certain limits, the monthly actuarial rate. The monthly actuarial rate for the prescription drug benefit for 1989 is $2.30.

Provides that for subsequent years, the Secretary will determine in September of each year, beginning with 1989, (a) the total benefits and administrative costs estimated to be paid from the Part B trust fund for each succeeding year for covered outpatient drugs and related administrative costs, and (b) a monthly actuarial rate for covered outpatient drugs applicable for the succeeding calendar year estimated so that the aggregate amount of the increase in drug premiums collected or received for such year will equal 75 percent of the total estimated cost of drug benefits and administrative costs.

Requires the Secretary to determine in September of each year, beginning in 1990, the aggregate amount of the increase in drug premiums collected or received during the previous year, the total benefits and administrative costs paid from the Part B trust fund during the previous year for covered outpatient drugs and related administrative costs, and whether the premiums were greater or less than 75 percent of the total paid from the Part B trust fund for drugs. Provides that if the Secretary determines that there was a surplus or deficit in the previous year, the monthly actuarial rate for covered outpatient drugs for the succeeding calendar year must be adjusted by the amount of the surplus or deficit.

If the drug premium increase is not a multiple of 10 cents, it will be rounded to the nearest multiple of 10 cents.

Requires the Secretary in September of each year beginning with 1989 to determine, for purposes of calculating the prescription drug factor used to adjust the supplemental premium yearly, the total monthly drug premium increases estimated to be collected or received in the succeeding year. The calculation is to be made as if the monthly actuarial rate (without regard to any adjustment for surplus or deficit in the previous year) were substituted for the basic monthly drug premium increase.

(2) Limit on Drug Benefit Premium Amount.—Provides a limit on the basic monthly drug premium amount as follows: not to exceed $3.40 in 1990, and in 1991 and subsequent years, not to exceed 120 percent of the basic monthly drug premium increase for months in the preceding year.

(3) Definitions.—No provision.

(4) Report on Projected Excess Premium Increases.—Requires the Secretary to report to Congress in May of each year beginning with 1990 concerning whether the Secretary anticipates that the monthly actuarial rate for the drug benefit for the succeeding year will exceed the limit on the basic monthly drug premium increase for that year. If so, the Secretary is required to include in the report recommendations for changes in policies under Part B sufficient to reduce Part B expenditures for covered outpatient drugs for the succeeding year so that the monthly actuarial rate (as reduced by such expenditure reductions) will not exceed the limit on the basic monthly drug premium amount for the year.

(d) Premium for In-Home Care Benefit.—

(1) Premium Amount.—Requires the Secretary, during September of 1988, 1989, and 1990, to determine (1) the total benefits and related administrative costs estimated to be paid from

the Part B trust fund in the succeeding calendar year for in-home care, and (2) a monthly actuarial rate for in-home care applicable in the succeeding calendar year. The monthly actuarial rate, subject to the adjustment described below, is an amount the Secretary estimates would be necessary so that the aggregate amount of the increase in premiums collected or paid for the year will equal 100 percent of the total benefits and administrative costs paid from the Part B trust fund.

Requires the Secretary in September of 1990, to determine the aggregate amount of the monthly premium increases collected or received for the in-home care benefit during the previous year, the total benefits and administrative costs which were paid in the previous year from the Part B trust fund for in-home care, and whether the amount of the premiums is greater or less than 100 percent of the total costs.

Provides that if the Secretary determines that there was a surplus or deficit in 1989, the Secretary must adjust the monthly actuarial rate otherwise determined for in-home care for 1991 to reduce or increase the aggregate amount of the monthly premium increase accordingly.

Provides that the monthly Part B premium of each individual enrolled in Part B for each month in a year after December 1988 and before January 1992 will be increased by the monthly actuarial rate for that year for the in-home care benefit, except that if the increase is not a multiple of 10 cents, it will be rounded to the nearest multiple of 10 cents.

(2) Limit on In-Home Care Benefit Premium Amount.—Provides that the increase in the monthly premium for the in-home benefit may not exceed in 1989, $0.30; in 1990, $0.50; and in 1991, 120 percent of the monthly premium increase in 1990. If the monthly actuarial rate for 1991 exceeds 120 percent of the monthly premium increase in 1990, the Secretary is required to decrease the maximum number of hours of in-home care in 1991 by such an amount that will assure that the aggregate amount of the monthly premium increase collected or paid for 1991 for all enrollees is equal to the total benefits and administrative costs estimated to be paid from the Part B trust fund in 1991 for in-home care.

Provides for certain conforming amendments.

(e) Monthly Premiums for Residents of U.S. Commonwealths and Territories.—

(1) Part B Premium.—Provides a separate Part B premium calculation for Medicare beneficiaries who are residents of a commonwealth or territory, defined as Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands.

For such residents during a month in 1988 or 1989, their monthly Part B premium otherwise determined is increased by one-twelfth of the product of: the average per capita additional benefits and related administrative costs due to the amendments in this bill, excluding benefits under section 202 (prescription drugs and insulin) and section 203 (in-home care), as determined by the Secretary during September of the previous year, times the following ratio. The ratio (determined by the

Secretary for that commonwealth or territory during September 1987) is (1) the per capita actuarial value of Medicare benefits for residents of the commonwealth or territory who are entitled to both Part A and Part B benefits, divided by (2) the per capita actuarial value of the Medicare benefits for residents of the United States who are entitled to both Part A and Part B benefits.

Provides that for 1990, the monthly Part B premium for such residents would be the monthly Part B premium otherwise determined for months in 1989, plus the increase for 1989 described above, increased by the Social Security COLA percentage increase for 1990.

For succeeding years, the Part B premium is the previous year's monthly amount, increased by the Social Security COLA for that year.

Provides that if any premium amount is not a multiple of 10 cents, it is rounded to the nearest multiple of 10 cents.

(2) Drug Premium for Residents of Commonwealth or Territories.—Provides that for residents of a commonwealth or territory, the monthly Part B premium is increased by the product of 133⅓ percent of the basic monthly drug premium for that year, times the ratio determined by the Secretary for that commonwealth or territory. The ratio is the per capita actuarial value of Medicare benefits for residents of the commonwealth or territory entitled to Medicare Part A and Part B, divided by the per capita actuarial value of Medicare benefits for residents of the United States entitled to Medicare Part A and Part B.

(f) Monthly Premiums for Individuals Enrolled Under Part B But Not Entitled to Benefits Under Part A.—

(1) Part B Premium.—Provides a separate Part B premium calculation for Part B only individuals. Defines such persons as those who: (1) are not residents of a commonwealth or territory as defined in the bill; (2) are entitled to Part B benefits; and (3) are not entitled to, or on application without payment of an additional premium would not be entitled to, benefits under Part A.

Provides that in 1989, the monthly Part B premium is the monthly Part B premium otherwise determined under current law, increased by one-twelfth of the per capita additional benefits and related administrative costs that the Secretary estimates will be paid under Part B during 1989 because of the amendments made by this bill, excluding benefits under section 202 (prescription drugs and insulin) and section 203 (in-home care).

Provides that in 1990, the monthly Part B premium is the 1989 monthly premium otherwise determined under section 1839(a)(3), plus the increase for 1989 determined above, increased by the percentage increase in the Social Security COLA for 1990. For succeeding years, provides that the monthly Part B premium is the amount for months in the previous year increased by the percentage increase in the Social Security COLA for that year. If any amount is not a multiple of 10 cents, it will be rounded to the nearest multiple of 10 cents.

(2) Drug Premium for Part B Only Individuals.—Provides that for individuals enrolled under Part B but not entitled to benefits under Part A, the monthly Part B premium will be increased by 133⅓ percent of the basic monthly drug premium increase for that year.

(g) Transfers to Catastrophic Health Insurance Trust Fund.—No provision.

Effective date.—Provides that the transitional adjustment described in (b), above, applies to monthly premiums for months beginning with January 1991; (c) (related to premiums for the prescription drug benefit) applies to monthly premiums for months beginning with January 1989; (d) (related to premiums for in-home care) applies to monthly premiums for months beginning with January 1989 and ending with December 1991; (e) (related to premiums for residents of commonwealths and territories) applies to monthly premiums for months beginning with January 1988; and (f) (related to premiums for Part B only individuals, and for the conforming amendments) applies to monthly premiums for months beginning with January 1989.

Senate amendment

(a) In General.—Provides for increases to the monthly Part B premium to finance the catastrophic coverage benefit (beginning in 1988) and the prescription drug benefit (beginning in 1990).

Provides that the Part B premium would be calculated as under current law, except that the monthly actuarial rate for aged enrollees and for disabled enrollees would be referred to as the monthly actuarial basic rate for each group, respectively, and that such rate would exclude the costs of comprehensive catastrophic coverage benefits (defined as those payable by Medicare as a result of the enactment of sections 2(a), 3(a), 7(b), 7A, and 11 of this bill) and related administrative costs.

Suspends hold harmless provision for 1988 and reimposes hold harmless for 1989 and thereafter.

(b) Catastrophic Coverage Premium.—

(1) Premium Amount.—Provides that the monthly catastrophic coverage premium amount for 1988 for individuals covered by Part A and Part B of Medicare is $4.

(2) Indexing.—Provides that the monthly coverage premium amount for succeeding calendar years is the previous year's amount, increased by the following percentage. The percentage equals:

(a) the percentage (if any) necessary to increase the estimated total revenues collectible from the monthly catastrophic coverage premiums and the supplemental premiums (determined without regard to the drug premium rate adjustment amount) for the succeeding year by the amount by which the estimated total catastrophic coverage benefits and related administrative costs (including administrative costs for outpatient drug coverage) for such succeeding year exceed such revenues, plus

(b) a percentage related to establishing and maintaining a contingency or a reserve fund.

Provides that the percentage increase for a contingency or a reserve fund for a calendar year before 1993 is the percentage the Secretary determines to be necessary to ensure that before 1993 there is established a contingency fund equal to 20 percent or (if greater) a reserve fund equal to 5 percent. For calendar years after 1992, the percentage is the percentage necessary to maintain either of such funds at such percentages.

Defines "contingency fund" for any calendar year as the percentage determined by dividing (1) the amount of unexpended catastrophic coverage premiums and supplemental premiums (without regard to the drug premium rate adjustment amount) as determined at the end of such year, by (2) the actuarial comprehensive catastrophic benefit amount for the succeeding calendar year.

Defines "reserve fund" for any calendar year as the percentage determined by dividing (1) the amount of unexpended and unobligated catastrophic coverage premiums and supplemental premiums (without regard to the drug premium rate adjustment amount) as determined at the end of such year, by (2) the actuarial comprehensive catastrophic benefit amount for the succeeding calendar year.

Provides that if any monthly premium amount is not a multiple of 10 cents, it will be rounded to the nearest multiple of 10 cents.

Defines "catastrophic coverage benefits" as the benefits payable by Medicare because of the enactment of the catastrophic coverage provisions in section 2(a), 3(a), 4 and 7(b) of this bill.

Defines "actuarial comprehensive catastrophic benefit amount" for any calendar year as the amount that the Secretary estimates will equal the total of the catastrophic coverage benefits (and related administrative costs) that will be payable from the Federal Catastrophic Health Insurance Trust Fund in that calendar year for Part B enrollees.

Provides that for calendar years after 1988, for enrollees who were entitled to Social Security benefits for November and December of the preceding year and who have the Part B premium deducted from their Social Security checks for December and January, their monthly Part B premium cannot be increased due to the catastrophic benefits if such increase would reduce their Social Security Benefits payable for that January below the benefits payable for that December (after the deduction of the Part B premium).

(c) Premium for Prescription Drug Benefit.—Amends Section 1839 (amount of the Part B premium) to provide that the Part B premium be increased by the monthly catastrophic drug benefit premium amount for the prescription drug benefit:

(1) Premium Amount.—Provides that the monthly catastrophic drug benefit premium amount for any calendar year after 1989 for individuals who are covered by Part B will be an amount equal to 50 percent (40 percent for calendar year 1990 and 45 percent for calendar year 1991, as provided in section 27 of the bill) of the per enrollee actuarial catastrophic drug benefit amount for such year, plus (a) in calendar year 1990, an amount necessary to cover 7.5 percent of the per enrollee

actuarial catastrophic drug benefit amount for 1991 (for a contingency fund), and (b) for calendar years after 1990, an amount (when added to any unexpended amount in the contingency fund for the previous year) necessary to cover 7.5 percent of the per enrollee actuarial catastrophic drug benefit amount for such calendar year.

Provides in section 27 of the bill that for calendar years after 1990, if the Secretary determines that (a) it is appropriate to increase the contingency fund to assure a smooth transition from cash outlays accounting to costs incurred accounting over a multiyear period, and (b) the monthly catastrophic drug benefit premium amount for that year is less than the drug premium limit, the Secretary is authorized to increase the drug premium by no greater than 15 percent, not to exceed the drug premium limits in the bill. Once the transition has been completed, requires the Secretary to maintain the drug benefit contingency fund on the basis of such cost incurred accounting method.

Provides that if the monthly drug benefit premium amount is not a multiple of 10 cents, if will be rounded to the nearest multiple of 10 cents.

(2) Limit on Drug Benefit Premium Amount.—Provides that in calendar years after 1991, the monthly catastrophic drug benefit premium amount cannot exceed $0.90 for 1990 (as provided in section 27 of the bill), $2.00 for 1991, $3.50 for 1992, $4.05 for 1993 (as provided in section 27 of the bill), and for any succeeding year, the amount for the preceding year increased by the percentage by which the Part B beneficiary drug expenditure amount for the 12-month period ending in August in that preceding year exceeds the Part B beneficiary drug expenditure amount for the 12-month period ending in August in the second preceding year.

(3) Definitions.—Defines "catastrophic drug coverage benefits" to mean benefits payable under Part B of Medicare because of the enactment of section 7A (coverage of home intravenous drug therapy) and section 11 (coverage of catastrophic expenses for prescription drugs) of this bill.

Defines "per enrollee actuarial catastrophic drug benefit amount" to mean, with respect to a year, an amount equal to the actuarial catastrophic drug benefit amount for the year divided by the total number of individuals that the Secretary estimates will be enrolled under Part B for the year.

Defines "actuarial catastrophic drug benefit amount" to mean, with respect to a calendar year, the amount that the Secretary estimates will equal the total of the catastrophic drug coverage benefits (and related administrative costs) that will be paid in cash outlays from the Federal Catastrophic Drug Insurance Trust Fund in such calendar year for Part B enrollees.

Defines "Part B beneficiary drug expenditure amount" to mean, with respect to a 12-month period, the average per capita amount expended for a period on outpatient prescription drugs by Part B enrollees (other than such enrolless en-

rolled in a health maintenance organization, a competitive medical plan, or a health care prepayment plan).

(4) Report on Projected Excess Premium Increases.—No provision. (See section 11 of the Senate amendment relating to Secretarial authority to institute cost control measures to assure that the drug premiums do not exceed the premium limits.)

(d) Premium for In-Home Care Benefit.—No provision.

(e) Monthly Premiums for Residents of U.S. Commonwealths and Territories.—No provision.

(f) Monthly Premiums for Individuals Enrolled Under Part B But Not Entitled to Benefits Under Part A.—

(1) Part B Premium.—Provides that the monthly castastrophic coverage premium amount (which is added to the monthly Part B premium otherwise determined) for individuals who are covered by Part B but not by Part A is an amount that bears the same ratio to the monthly catastrophic coverage premium amount for individuals covered by both Part A and Part B of Medicare, as the actuarial Part B catastrophic benefit amount for that year bears to the actuarial comprehensive catastrophic benefit amount for that year.

Defines the actuarial Part B catastrophic benefit amount for a calendar year as the amount the Secretary estimates will equal the catastrophic coverage benefits and related administrative costs payable from the Federal Catastrophic Health Insurance Trust Fund for that year with respect to such enrollees (excluding any amounts attributable to changes under Sections 2(a), 3(a), and 7(b) of this bill in services performed and related administrative costs incurred in that year for individuals covered under Part A).

Provides that if the monthly premium amount is not a multiple of 10 cents, it will be rounded to the nearest multiple of 10 cents.

(2) Drug Premium for Part B Only Individuals.—No provision. (The drug premium for Part B only individuals is calculated in the same manner as for Medicare beneficiaries covered by both Part A and Part B).

(g) Transfers to Catastrophic Health Insurance Trust Fund.—Provides that there will be transferred from time to time from the Part B trust fund to the Federal Catastrophic Health Insurance Trust Fund amounts from Part B premiums that are attributable to the catastrophic coverage changes in services performed and related administrative costs incurred in a calendar year (under sections 2(a), 3(a), and 7(b) of this bill).

Provides that there will be transferred from time to time from the Part B trust fund to the Federal Catastrophic Drug Insurance Trust Fund amounts from the catastrophic drug benefit premiums.

Effective date.—Applies to premiums for months beginning after December 31, 1987.

Conference agreement

(a) *In General.*—The conference agreement provides for increases to the monthly Part B premium otherwise determined to finance the catastrophic coverage benefit and the prescription drug benefit. For 1993, revenues from the additional flat Part B premium are es-

timated to provide approximately 37 percent of the financing for the catastrophic coverage and prescription drug benefits, with the supplemental premium (see section 7, above) providing an estimated 63 percent of revenues. After 1993, the conferees intend that the proportion contributed by the flat premium will be 37 percent; however, the proportion could vary as a result of limits on the allowable change in the supplemental premium.

The conference agreement requires the Secretary of Health and Human Services and the Secretary of the Treasury jointly to (1) publish in the Federal Register, by not later than July 1 of each year beginning with 1993, a notice of the proposed preliminary catastrophic coverage and prescription drug monthly premiums for the following year; (2) report to Congress by no later than September 1 of each year the final premiums for the following year; and (3) publish in the Federal Register during the last three days in September of each year the final premiums for the following year.

The flat premium is adjusted to account for any changes in the supplemental premium resulting from limits specified in this Act (see section 7 for a description of these limits). The adjustment to the flat rate premium is calculated in three steps. First, the current year actual supplemental premium rate is subtracted from what the supplemental premium rate would have been if it had not been adjusted by the limits. This difference is known as either the excess or the shortfall rate. Then, the total supplemental premiums imposed in the second preceding year are compared to the total supplemental premiums as adjusted by the excess or shortfall rate. Finally, this difference is adjusted by the percentage by which the per capita catastrophic coverage premium liability (see section 7) for the second preceding year exceeds or is less than such liability for the fourth preceding year. The resulting amount is then used to establish the new per person monthly flat premium.

The conference agreement provides that the sum of the additional monthly premiums for catastrophic coverage and prescription drug coverage for months after 1993 cannot be less than the sum of these additional premiums for months in the preceding year. If this combined monthly premium is affected by the application of this provision, the premium increase is allocated between the catastrophic coverage premiums and the prescription drug premiums in the same proportion as if this provision had not applied.

If any flat premium increase for a month is not a multiple of 10 cents, it will be rounded to the nearest multiple of 10 cents. If so rounded, premiums will be allocated between the catastrophic coverage monthly premium and the prescription drug monthly premium on the basis of their respective amounts determined without regard to any rounding.

The conference agreement includes the Senate amendment regarding the "hold harmless" provision with a modification that the provision applies to both social security benefits and Railroad Retirement benefits and that such benefits may not decrease due to an increase in the Part B premium in any year.

(b) *Catastrophic Coverage Premium.*—(1) Premium Amount.—The conference agreement provides that the monthly catastrophic coverage premium will be as follows for months occurring in 1989 through 1993:

1989	$4.00
1990	4.90
1991	5.46
1992	6.75
1993	7.18

(2) *Indexing.*—The conference agreement provides that for months in a year after 1993, the catastrophic coverage monthly premium will be the preceding year's premium (without regard to any increase in the premium because it was less than the previous years' premium or because of any adjustment due to limits on the supplemental premium), adjusted by a percentage representing the sum of: (i) the outlay premium percentage, and (ii) the reserve account percentage.

The outlay-premium percentage is the percent by which the per capita catastrophic outlays in the second preceding year exceed (or are less than) such outlays in the third preceding year. An adjustment is provided for changes in the Consumer Price Index (CPI) as follows:

If the CPI's inflation rate increased from the third to the second preceding year, the outlay-premium percentage is adjusted by adding 50 percent of the excess (if any) of (i) the excess of the CPI inflation rate in the second over the third preceding year, over (ii) one percentage point. If the CPI inflation rate decreased from the third to the second preceding year, the outlay-premium percentage is adjusted by subtracting 50 percent of the excess (if any) of (i) the excess of the CPI inflation rate in the third over the second preceding year, over (ii) one percentage point. For this purpose, the CPI inflation rate for any year is defined as the percentage by which the CPI for May of such year exceeds such index for May of the preceding year.

The reserve account percentage for any calendar year is the percentage change in the catastrophic coverage monthly premium for the second preceding year which the Secretary determines would have increased (or decreased) the flat premiums for such year by an amount equal to 37 percent of the shortfall (or surplus) in the Medicare Catastrophic Coverage Account (the "Account") in such year. The shortfall (or surplus) in the Account for any calendar year is determined as the amount by which 20 percent of the catastrophic outlays from the Account in the second preceding year exceed (or are less than) the Account balance at the end of such year (taking into account falt and supplemental premium increases attributable to reserve percentages in prior years that have not yet been credited to the Account).

(c) *Premium for Prescription Drug Benefit.*—The conference agreement provides that the monthly prescription drug premium will be as follows for months occurring in 1991 through 1993:

1991	$1.94
1992	2.45
1993	3.02

For months in a year after 1993, the prescription drug premium will be the preceding year's premium, (without regard to any increase because the premium was less than the previous year's premium or because of any adjustment due to the limits on the supplemental premium), adjusted by a percentage determined in a

manner similar to that for the monthly catastrophic coverage premium, with the following changes: (1) in determining the outlay percentage, prescription drug outlays rather than catastrophic coverage outlays are used; (2) in determining the reserve percentage, the Federal Catastrophic Drug Insurance Trust Fund balance (see section 16, below) is used rather than the Account balance; (3) the reserve percentage is 75 percent for 1994, 50 percent for 1995, and 25 percent for 1996 and 1997, instead of 20 percent; and (4) the outlay percentage is deemed to be zero for calendar years before 1998.

(d) *Premium for In-Home Care Benefit.*—The conference agreement does not include the House provision. Revenues to fund the in-home (respite care) benefit are included in the monthly and supplemental catastrophic coverage premiums.

(e) *Monthly Premiums for Residents of U.S. Commonwealths and Territories.*—The conference agreement includes the House provision, with the following amendments. For individuals who are residents of Puerto Rico or of another U.S. commonwealth or territory (including the U.S. Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands), the monthly Part B premium otherwise determined would be increased by a catastrophic coverage monthly premium and a prescription drug monthly premium.

For months in 1989, the catastrophic coverage monthly premium is $1.30 for a resident of Puerto Rico and $2.10 for a resident of another U.S. commonwealth or territory. For months in 1990, the catastrophic coverage monthly premium is $3.56 for a resident of Puerto Rico and $5.78 for a resident of another U.S. commonwealth or territory.

For months in a subsequent year, the catastrophic coverage monthly premium is the resident's preceding year's premium increased by the Secretary's estimate (in September of that preceding year) of the percentage increase in the per capita catastrophic outlays from the Catastrophic Account for the year over such outlays for the preceding year.

For months in 1990, the prescription drug monthly premium is $0.14 for a resident of Puerto Rico and $0.22 for a resident of another U.S. commonwealth or territory. For months in 1991, the prescription drug monthly premium is $1,21 for a resident of Puerto Rico and $1.93 for a resident of another U.S. commonwealth or territory.

For months in a subsequent year, the prescription drug monthly premium is the resident's preceding year's premium increased by the Secretary's estimate (in September of that preceding year) of the percentage increase in the per capita prescription drug outlays from the Federal Catastrophic Drug Insurance Trust Fund for the year over such outlays for the preceding year.

The Secretary is required to report to Congress, in 1993, on the appropriateness of the level of the Part M premium increases for residents of Puerto Rico and of other U.S. commonwealths and territories.

(f) *Monthly Premiums for Individuals Enrolled Under Part B But Not Entitled to Benefits Under Part A.*—The conference agreement includes the House provision, with amendments. The agreement provides that for individuals who are entitled to Part B of Medi-

care but are not entitled to Part A, or would not be entitled to Part A but for payment of the Part A premiums, and who are not residents of a commonwealth or territory, the monthly Part B premiums will be determined as follows. The monthly Part B premium otherwise determined will be increased by a catastrophic coverage monthly premium and a prescription drug monthly premium.

For months in 1990, the catastrophic coverage monthly premium is $8.57, and for months in a subsequent year the premium is one-twelfth of the average actuarial expenses that the Secretary estimates (during the previous September) will be incurred for benefits and administration costs attributable to Part B for which outlays may be made from the Medicare Catastrophic Coverage Account during the year.

The prescription drug monthly premium is $0.53 for months in 1990, $4.61 for months in 1991, and for months in a subsequent year the premium is one-twelfth of the average actuarial expenses that the Secretary estimates (during the previous September) will be incurred for benefits and administration costs attributable to Part B for which outlays may be made from the Federal Catastrophic Drug Insurance Trust Fund during the year.

(g) *Transfers to Catastrophic Health Insurance Trust Fund.*—The conference agreement does not include the Senate amendment. The catastrophic coverage monthly premium is credited to the Medicare Catastrophic Coverage Account and transferred to the SMI Trust Fund.

(h) *Conforming Amendments.*—The conference agreement provides for certain conforming amendments, including (1) those to disregard the receipts and outlays attributable to changes made by this Act when determining (i) the monthly actuarial rate used to establish the Part B premium for aged and disabled beneficiaries, and (ii) the appropriate contingency margin for the PART B trust fund; (2) a provision to disregard the flat and supplemental catastrophic coverage and prescription drug premiums when computing appropriations to the Part B trust fund from the Treasury; and (3) those authorizing payments from the Federal Catastrophic Drug Insurance Trust Fund to organizations with risk-sharing contracts and establishing a method for allocating payment to such organizations from the Part A, Part B, and the Federal Catastrophic Drug Insurance Trust Funds.

Effective Date:—The conference agreement applies (except as otherwise specified in such amendments) to monthly premiums for months beginning with January 1989.

16. Establishment of Federal Catastrophic Drug Insurance Trust Fund (Section 6A or Senate Amendment)

Present law

A separate trust fund exists in the Treasury of the United States for each part of the Medicare program: the Federal Hospital Insurance Trust Fund (Part A) and the Federal Supplementary Medical Insurance Trust Fund (Part B).

The Part A trust fund includes annual deposits of the hospital insurance taxes collected from employers, employees, and the self-employed, and the monthly Part A premiums from individuals not

otherwise eligible for Part A. The Part B trust fund includes deposits of the monthly Part B premiums paid by or on behalf of Part B enrollees, and contributions by the Federal Government from general revenues.

Section 1841 of the Social Security Act applies to the Federal Supplementary Medical Insurance Trust Fund as follows: Section 1841(b) creates and specifies the duties of a board of trustees for the trust fund; section 1841(c) provides for the investment of certain trust fund funds; section 1841(d) authorizes the selling of certain obligations acquired by the trust fund; section 1841(e) provides for the crediting of interest on or proceeds from the sale or redemption of any obligations held by the trust fund; section 1841(f) provides for periodic transfers to the trust fund from the Federal Old-Age and Survivors Insurance Trust Fund, the Federal Disability Insurance Trust Fund, and the Railroad Retirement Account; section 1841(g) provides for payments from the trust fund for Part B benefit payments and related administrative costs; section 1841(h) provides for payment from the trust fund for costs incurred by the Office of Personnel Management in deducting Part B premiums from Federal annuities; and section 1841(i) provides for payment from the trust fund for certain costs incurred by the Railroad Retirement Board.

House bill

No provisions.

Senate amendment

Creates on the books of the Treasury of the United States a trust fund known as the Federal Catastrophic Drug Insurance Trust Fund.

Provides that such trust fund consists of (1) any gifts and bequests made to the trust fund or to the Department of Health and Human Services for the benefit of the trust fund or any activity financed by the trust fund, and (2) the following amounts transferred to such trust fund: (a) drug benefit premiums transferred from the Part B trust fund, and (b) the drug premium rate adjustment component of the Medicare supplemental premium transferred from the general fund of the Treasury.

Provides that subsections (b) through (i) of section 1841 of the Social Security Act apply to such trust fund in the same manner as they apply to the Part B trust fund.

Requires that all Medicare payments for the home intravenous drug therapy benefit and the prescription drug benefit be made from this trust fund.

Effective date.—Applies to items and services furnished after, and premiums for months beginning after, December 31, 1987.

Conference agreement

The Conference agreement generally follows the Senate amendment. All payments for benefits and administrative costs relating to covered outpatient drugs are to be made from the CDI Trust Fund. The CDI Trust Fund has no borrowing authority.

Receipts attributable to the supplemental prescription drug premium rate are appropriated to the CDI trust fund. The Secretary

of the Treasury is to transfer these appropriated amounts from the general fund to the CDI trust fund not less frequently than monthly, and at the close of the calendar year, determined on the basis of estimates; adjustments are made in subsequent transfers to take account of estimating errors. For individuals paying the maximum supplemental premium, receipts are allocated between the supplemental prescription drug and catastrophic coverage premiums pro rata on the basis of the respective premium rates.

The Secretary of HHS shall transfer premiums attributable to the prescription drug monthly premium directly to the CDI trust fund rather than through the SMI Trust Fund.

The Secretaries of HHS and Treasury jointly shall: (1) not later than July 1 of 1993 and each year thereafter, announce the preliminary monthly and supplemental prescription drug premiums for the following year; (2) not later than July 1 of 1992 and each year thereafter, publish in the Federal Register the outlays from, and the year-end balance in the CDI trust fund for the preceding year; (3) during the last 3 days of September of 1993 and each year thereafter, publish in the Federal Register the monthly prescription drug premiums for the following year; and (4) not later than October of 1993 and end each year thereafter, announce the supplemental prescription drug premium rate for the following year. The Comptroller General shall report to Congress, not later than September 1 of 1992 and each year thereafter, on the completeness and accuracy of the July 1 Federal Register publication, and after 1992, on the July 1 premium announcement.

With respect to the CDI trust fund, "outlays" and "receipts" are defined as gross outlays and receipts within the meaning of the "Monthly Treasury Statement of Receipts and Outlays of the United States Government," as published by the Treasury Department.

Effective date.—The CDI trust fund provisions are effective after December 31, 1988.

17. Establishment of Federal Catastrophic Health Insurance Trust Fund (Section 6B of Senate Amendment)

Present law

A separate trust fund exists in the Treasury of the United States for each part of the Medicare program: the Federal Hospital Insurance Trust Fund (Part A) and the Federal Supplementary Medical Insurance Trust Fund (Part B).

The Part A trust fund includes annual deposits of the hospital insurance taxes collected from employers, employees, and the self-employed, and the monthly Part A premiums from individuals not otherwise eligible for Part A. The Part B trust fund includes deposits of the monthly Part B premiums paid by or on behalf of Part B enrollees, and contributions by the Federal Government from general revenues.

Section 1841 of the Social Security Act applies to the Federal Supplementary Medical Insurance Trust Fund as follows: Section 1841(b) creates and specifies the duties of a Board of Trustees for the trust fund; section 1841(c) provides for the investment of certain trust fund funds; section 1841(d) authorizes the selling of cer-

tain obligations acquired by the trust fund; section 1841(e) provides for the crediting of interest on or proceeds from the sale or redemption of any obligations held by the trust fund; section 1841(f) provides for periodic transfers to the trust fund from the Federal Old-Age and Survivors Insurance trust fund, the Federal Disability Insurance trust fund, and the Railroad Retirement Account; section 1841(g) provides for payments from the trust fund for Part B benefit payments and related administrative costs; section 1841(h) provides for payment from the trust fund for costs incurred by the Office of Personnel Management in deducting Part B premiums from Federal annuities; and section 1841(i) provides for payment from the trust fund for certain costs incurred by the Railroad Retirement Board.

House bill

No provision.

Senate amendment

Creates the books of the Treasury of the United States as a trust fund known as the Federal Catastrophic Health Insurance Trust Fund.

Provides that such trust fund consists of (1) any gifts and bequests made to the trust fund or to the Department of Health and Human Services for the benefit of the trust fund or any activity financed by the trust fund, and (2) the following amounts transferred to such trust fund: (a) amounts from the Part B premiums attributable to the catastrophic benefit changes (excluding the drug benefit) in this bill, transferred from the Part B trust fund, and (b) the aggregate monthly supplemental premiums (excluding the drug premium rate adjustment) plus the amount the Secretary of the Treasury estimates Federal outlays are reduced under Medicaid because of the catastrophic provisions of this bill (after taking into account the provisions of section 14 of the bill related to Medicaid savings and State requirements), transferred from the general fund of the Treasury.

Provides that subsections (b) through (i) of section 1841 of the Social Security Act apply to such trust fund in the same manner as they apply to the Part B trust fund.

Requires that all Medicare payments for the catastrophic benefits in sections 2(a), 3(a), 4, and 7(b) of this bill be made from this trust fund.

Effective date.—Applies to items and services furnished after, and premiums for months beginning after, December 31, 1987.

Conference agreement

(a) *Medicare Catastrophic Coverage Account.*—The conference agreement does not include the Senate amendment. A separate Medicare Catastrophic Coverage Account (the "Account") is established on the books of the Treasury of the United States, to be maintained by the Secretary of the Treasury.

No funds are transferred into or out of the account. The principal purpose of the Account is to index the monthly and supplemental catastrophic coverage premium rates and to assure that over time revenue from these premiums are at least as large as the out-

lays from the Parts A and B trust funds attributable to the Medicare Catastrophic Coverage Act of 1988. (See discussion of premium indexing under section 7 above.)

Under rules prescribed by the Secretary of HHS, the Account is to be debited for catastrophic outlays. Catastrophic outlays are defined as outlays from the HI and SMI trust funds estimated to be attributable to the Catastrophic Coverage Act of 1988; HI and SMI outlays are to be separately debited from the Account. The Account is to be credited for monthly catastrophic coverage premiums received in the SMI trust fund and supplemental catastrophic coverage premiums received in the SMI trust fund and the Reserve Fund. Such credits and debits shall be made as of the last date of each month based upon receipts and outlays occurring during such month, as estimated by the Secretaries of HHS and Treasury. Interest (at the rate used for purposes of the SMI trust fund) is credited on any positive average Account balance in a calendar quarter and debited on any negative average Account balance in a calendar quarter. Thus, if the Account balance is negative, the Account is debited for principal and interest deemed to be owed to the SMI trust fund.

The Secretaries of HHS and Treasury jointly shall: (1) not later than July 1 of 1993 and each year thereafter, announce the preliminary monthly and supplemental catastrophic coverage premiums for the following year; (2) not later than July 1 of 1990 and each year thereafter, publish in the Federal Register the outlays debited from, and the year-end balance in the Account for the preceding year; (3) during the last 3 days of October of 1993 and each year thereafter, publish in the Federal Register the monthly and catastrophic coverage premiums for the following year; and (4) not later than October 1 of 1993 and each subsequent year, announce the supplemental catastrophic coverage premium rate for the following year. The Comptroller General shall report to Congress, not later than September 1 of 1990 and each year thereafter, on the completeness and accuracy of the July 1 Federal Register publication and, after 1992, and July 1 premium announcement.

Catastrophic health insurance benefits, other than prescription drug and home intravenous therapy benefits, are paid out of the existing medicare Parts A and B trust funds.

Receipts attributable to the supplemental catastrophic coverage premium rate, which are not otherwise appropriated to the Federal Hospital Insurance Catastrophic Coverage Reserve Fund (the "Reserve Fund"), are appropriated to the SMI trust fund. The Secretary of the Treasury is to transfer these appropriated amounts from the general fund to the SMI trust fund not less frequently than monthly, and at the close of the calendar year, determined on the basis of estimates; adjustments are made in subsequent transfers to take account of estimating errors. For individuals paying the maximum supplemental premium, receipts are allocated between the supplemental prescription drug and catastrophic coverage premiums pro rata on the basis of the respective premium rates.

The Secretary of HHS shall transfer receipts from the monthly catastrophic coverage premium to the SMI trust fund in the same manner as the existing Part B monthly premium.

These supplemental and monthly catastrophic coverage premiums are intended to increase Federal government receipts by the cost of catastrophic coverage benefits (plus a contingency margin).

No additional revenues are transferred to the Part A trust fund.

Effective date.—The Account is effective after December 31, 1988.

(b) *Federal Hospital Insurance Catastrophic Coverage Reserve Fund.*—To prevent an adverse effect on the HI trust fund balance, a new trust fund, to be known as the "Federal Hospital Insurance Catastrophic Coverage Reserve Fund," (the "Reserve Fund") is established on the books of the Treasury of the United States. The Conferees anticipate that Congress may at some future time transfer funds from the Reserve Fund to the HI trust fund to bolster the solvency of the trust fund. No expenditures from the Reserve Fund are permitted.

The rules for managing the Reserve Fund generally are similar to the rules that apply to the SMI trust fund.

Beginning in 1989, supplemental catastrophic coverage premiums are appropriated to the Reserve Fund, but not exceeding the amount of outlays from the HI trust fund that are debited against the Account. The Secretary of the Treasury is to transfer these appropriated amounts from the general fund to the Reserve Fund not less frequently than monthly, and at the close of the calendar year, determined on the basis of estimates; adjustments are made in subsequent transfers to take account of estimating errors. For individuals paying the maximum supplemental premium, receipts are allocated between the supplemental prescription drug and catastrophic coverage premiums pro rata on the basis of the respective premium rates.

The Secretary shall in July 1990 transfer an amount of supplemental catastrophic coverage premiums to the Reserve Fund equal to interest deemed to accrue (at the rate used for purposes of the SMI trust fund) from the time HI outlays are debited from the Account in 1989, until the time an equal amount of supplemenal catastrophic coverage premiums are transferred to the Reserve Fund.

Receipts attributable to the supplemental catastrophic coverage premium are first transferred to the Reserve Fund and then, to the extent available, transferred to the SMI trust fund, as described in section 17, above. (Such premium receipts are credited to the Account, whether transferred to the Reserve Fund or the SMI trust fund.)

With respect to the Reserve Fund, "outlays" and "receipts" are defined as gross outlays and receipts within the meaning of the "Monthly Treasury Statement of Receipts and Outlays of the United States Government," as published by the Treasury Department.

Effective date.—The Federal Health Insurance Reserve Fund provisions are effective after December 31, 1988.

18. Trustee Comments on Actuarial Soundness of Basic and Supplemental Catastrophic Benefit Premiums (Section 18 of Senate amendment)

Present law

The Social Security Act currently requires that the Trustees of the Hospital Insurance (HI) and Supplementary Medical Insurance (SI) trust funds report to the Congress not later than April 1 of each year on the operation and status of the trust funds during the preceding fiscal year and on their expected operation and status during the current fiscal year and the next 2 fiscal years.

House bill

No provision.

Senate amendment

Amends section 1817(b) relating to the HI trust fund and 1841(b) relating to the SMI trust fund by inserting a requirement that the Trustees comment in their annual reports with respect to the extent to which the monthly catastrophic coverage premium and the supplemental premium cover the cost of the catastrophic benefits (as defined in section 1839(g)(2)(C)(i) added by this Act) and related administrative expenses payable from the trust funds.

Effective date.—Effective for trustees' annual reports beginning with those issued for fiscal year 1988.

Conference agreement

Under the Conference agreement, the Trustees annual reports on the HI and SMI trust funds are to identify those receipts and outlays in each trust fund which are deemed to be receipts and outlays in the Medicare Catastrophic Coverage Account (see section 17, above). In addition, the HI report is to include information pertaining to the Federal Hospital Insurance Catastrophic Coverage Reserve Fund.

The trustees of the CDI trust fund and the Account are to report to the Congress, not later than April 1 of each year, on the operation and status of the CDI trust fund and Account during the preceding fiscal year and on their expected operation and status during the current fiscal year and the next two fiscal years.

Effective date.—Effective for Trustees' annual reports beginning with those issued for fiscal year 1989.

19. Treatment of Prepaid Health Plans (Section 207 of House bill; Section 10 of Senate amendment).

Present law

Section 1876 of the Social Security Act, as amended by the Tax Equity and Fiscal Responsibility Act of 1982, provides for Medicare payments to Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs) on either a risk or a cost contracting basis. In general, risk contracting plans are financially responsible for the cost of all benefits their enrollees would otherwise be eligible for under Medicare. Reimbursement of HMOs and CMPs is de-

termined based on estimates of the average adjusted per capita cost (AAPCC) and the adjusted community rate (ACR).

House bill

(a) Adjustment of AAPCC's and Contracts for Risk-Based Eligible Organizations.—Requires the Secretary to: (1) take into account amendments made by this act in estimating the AAPCC under section 1876(a) for eligible organizations with risk sharing contracts under section 1876(a) for portions of contract years occurring after December 31, 1987; (2) modify such contracts, for such portions of contract years, to reflect any adjustments made to the AAPCCs (as required above); and (3) require such organizations to make appropriate adjustments (including adjustments in premiums and benefits) in terms of their agreements with Medicare beneficiaries to take into account the changes in law required by this act.

(b) Provisions Applicable to Organizations Receiving Reasonable Cost Reimbursement.—Specifics that the following new provisions of this act apply to organizations reimbursed on the basis of reasonable costs: Section 201(a)(1) relating to payment for catastrophic benefits; section 202(b)(1)(C) relating to payment for covered out-patient drugs; section 203(c)(3) relating to payment for in-home care.

Requires the Secretary to provide for an appropriate adjustment in Medicare payment amounts to cost-based HMOs for added benefits.

Requires such organizations to assure the Secretary that they will not charge individuals eligible for:

Medicare catastrophic coverage for covered services after the individual has incurred out-of-pocket expenses equal to the catastrophic limit; or

More than 20 percent of reasonable cost of covered drugs plus amounts payable due to deductibile; or

More than 20 percent of reasonable costs of respite services plus an amount payable due to the deductible.

Effective date.—Enactment.

Senate amendment

(a) Adjustment of AAPCC's and Contracts for Risk-Based Eligible Organizations.—Similar provision except requires the Secretay to: (1) modify any AAPCC under section 1876(a) for an eligible organization with a risk-sharing contract to take into account the amendments made by section 2(a) of this bill relating to benefits for hospital inpatient services, section 3(a) relating to deductibles and coinsurance for individuals under parts A and B, section 4 relating to limitations on out-of-pocket expenses, section 7(b) relating to payment for in-home care, section 7A relating to home intravenous drug therapy, and section 11 relating to prescription drugs; (2) modify each such contract for portions of contract years occurring after December 31, 1987 to reflect the modifications made (as required above); and (3) require such organizations to make appropriate adjustments in terms of its agreements with Medicare beneficiaries to take into account such amendments.

(b) Provisions Applicable to Organizations Receiving Reasonable Cost Reimbursement.—No provision. See section 4 of the Senate amendment (Item 9e) relating to limitations on cost sharing.

Effective date.—Enactment.

Conference agreement

(a) *Adjustment of AAPCCs and Contracts for Risk-Based eligible Organizations.*—The conference agreement requires the Secretary to modify contracts under sections 1833 and 1976 for portions of contract years occurring after December 31, 1988. Prepaid plans are required to adjust their benefit packages to take the new benefits into account. The AAPCC will be adjusted to take the new beenfits into account under current authority. For provisions describing the treatment of copayments and deductibles when a beneficiary is enrolled in a pre-paid plan reimbursed on a risk basis, see item 9(e).

In assessing the value of benefits under prepaid plans paid on a risk basis the Secretary is required to make a separate actuarial determination for drug benefits and for all other covered benefits.

(b) *Provisions Applicable to Organizations Receiving Reasonable Cost Reimbursement.*—The conference agreement does not include the House provision. For provisions applicable to organizations reimbursed on a reasonable cost basis, see items 9(e), 10(f), and 12(c).

Effective date.—The conference agreement is effective on enactment.

20. Mailing of Notice of Medicare Benefits and Participating Physician Directories (Section 208 of the House bill; Section 9 of Senate amendment)

Present law

Under existing law, there is no requirement for an annual notice to Medicare beneficiaries about the scope of benefits available to them under the Medicare program. Information on Medicare coverage is generally available through the Social Security Administration district offices. As part of the participating physician program created by Public Law 98-369, the Deficit Reduction Act (DEFRA), HHS prepares directories of participating physicians, by area and specialty. These directories are made available in local Social Security offices, through hospitals, and through aging and consumer groups. Also, enrollees are informed by a notice in their Social Security check envelopes that they can obtain a copy free from their Medicare carrier. As of October 1, 1986, all "Explanation of Medicare Benefits" notices sent to beneficiaries on unassigned claims have to include a reminder of the participating physician and supplier program.

House bill

(a) Distribution of Notice of Medicare Benefits.—Amends the Medicare statute by adding new section 1804. Section 1804(a) requires the Secretary to distribute annually a notice containing: (1) a clear, simple explanation of the benefits available under Medicare and health care services for which benefits are not available under Medicare; and (2) a description of the limited benefits for

long-term care services available under this title and generally available under State plans approved under Medicaid. Requires the notice to be mailed annually to individuals entitled to Medicare Part A or Part B benefits.

(b) Authorization of Funds.—Amends the Medicare statute by adding a new provision (1804(b)) which authorizes, to be appropriated in equal portions from the HI and SMI trust funds, such sums as may be required to provide for the annual publication and distribution of the notice described in (a).

(c) Distribution of Participating Physician Directories.—Amends section 1842(h)(6) of the Medicare law relating to participating physician directories to require that an area directory of participating physicians be sent to each individual enrolled under Part B and residing in that area.

(d) Timing.—Requires the Secretary to provide notice annually.

(e) Consultation Required.—No provision.

Effective date.—First applies to annual rates and directories for 1988. The annual notice would be sent by January 31, 1988, or 3 months after the date of enactment of this legislation.

Senate amendment

(a) Distribution of Notice of Medicare Benefits.—Requires the Secretary to notify each individual who is entitled to benefits under Medicare of: (1) the benefits that are available under the insurance programs established under Medicare (and the major categories of health care that are not covered under those programs); (2) the limitations on payment (including deductibles and coinsurance amounts) that are imposed under such programs; and (3) the ways in which such limitations differ for individuals who are covered under the program established under Part B and individuals who are not covered under Part B.

(b) Authorization of Funds.—No provision.

(c) Distribution of Participating Physician Directories.—No provision.

(d) Timing.—Requires the Secretary to provide the notice described in (a) when an individual applies for benefits under Part A or enrolls under Part B, and annually thereafter.

(e) Consultation Required.—Requires the notices to be prepared in consultation with groups representing the elderly and with health insurers.

Effective date.—The requirement for notices for new beneficiaries is effective January 1, 1988. The notice to all beneficiaries applies to annual notices beginning for 1988.

Conference agreement

(a) *Distribution of Notice of Medicare Benefits.*—The conference agreement includes the House provision with modifications. The notice must include, in addition, information on Medicare's limitations on payment (including deductible and coinsurance amounts).

(b) *Authorization of Funds.*—The conference agreement does not include the House provision. General authority already exists in Section 201(g)(1)(A) of the Social Security Act to use Part A and Part B Trust Fund amounts for administrative expenses of the Medicare program.

(c) *Notice Concerning Participating Physicians.*—The conference agreement does not include the House provision requiring distribution of participating physicians directories, but instead modifies current law requirements for notice to beneficiaries regarding the participation program.

The agreement revised the reminder of the participation program currently required on the explanation of medical benefit (EOMB) notices for unassigned claims. The revised reminder would include: (i) a clear statement of the extra amounts (if any) charged by the physician above the Medicare approved charge; (ii) a brief statement of the advantages of receiving services from a participating physician; and (iii) the carrier's toll-free number with an offer of assistance in obtaining names of participating physicians of appropriate specialty and an offer of a free copy of the appropriate participating physician directory.

The conferees expect that the Secretary will consult closely with groups representing beneficiaries and physicians in developing the notice to assure that it can be easily understood by the elderly and conveys an accurate understanding of program policies.

The conferees expect that the revised reminder would be printed in a prominent type face (where possible) near the beginning of the explanation of medical benefits.

The conference agreement also modifies current requirements for an annual notice to beneficiaries concerning the participating physician program. The revised notice (which would be in the form of a brochure) would be mailed to each beneficiary each year and would contain: (i) a description of the participation program; and explanation of the advantages of obtaining services from a participating physician or supplier; (ii) an explanation of the assistance offered by carriers in obtaining the names of participating physicians and suppliers; and (iii) the local carrier's toll free number for inquiries concerning the program and for requests for free copies of appropriate directories.

The conferees note that the provisions are based on options developed by the Physician Payment Review Commission in its March 1988 report to Congress and are similar to measures used by private insurers to publicize and facilitate the use of their participating physician networks.

(d) *Timing.*—The conference agreement includes the House provision regarding distribution of the annual notice required under subparagraph (a) with an amendment that such notices must also be mailed annually when an individual applies for benefits under Part A or enrolls under Part B.

(e) *Consultation Required.*—The conference agreement specifies that the Secretary must first distribute the notice required under subparagraph (a) to beneficiaries not later than January 31, 1989. The revised EOMB notice applies to services furnished on or after January 1, 1989. The revised annual notice regarding the participation program would apply to annual notices beginning with 1989.

21. Benefits Counseling and Assistance for Certain Medicare and Medicaid Beneficiaries (Section 9A of Senate amendment)

Present law

No provision.

House bill

No provision.

Senate amendment

(a) Training and Technical Assistance.—Authorizes the Secretary to enter into agreements with private or public nonprofit agencies or organizations for the purpose of training volunteers. These volunteers are to provide counseling to elderly individuals, ages 60 and above, receiving benefits under Medicare or Medicaid with respect to eligibility for such benefits and are to provide assistance in preparing documentation that may be required to receive such benefits. In addition to other specified forms of technical assistance, the Secretary may provide material to be used in making elderly persons aware of the availability of assistance under volunteer assistance programs. The Secretary may also provide technical publications and materials to be used by the volunteers.

(b) Powers of the Secretary.—Authorizes the Secretary: (1) to provide assistance to organizations which demonstrate that their volunteers are adequately trained and competent to render effective benefits counseling and assistance to the elderly; (2) to provide for and assist in the training of such volunteers; (3) to provide reimbursement to volunteers for transportation, meals, and other expenses incurred by them during training or in providing counseling and assistance, and to provide such other support as the Secretary deems appropriate; (4) to provide for the use of services, personnel and facilities of the Federal executive agencies and of State and local public agencies with their consent, with or without reimbursement; and (5) to prescribe such rules and regulations as the Secretary deems necessary.

(c) Employment of Volunteers.—Provides that service as a volunteer under this section shall not be considered Federal employment. Volunteers are not subject to provisions of law relating to Federal employment, except that the volunteers are subject to the prohibition against the unauthorized disclosure of confidential information as if they were Federal employees. Reimbursement for expenses received by the volunteers are exempt from taxation.

(d) Authorization of Appropriations.—Authorizes to be appropriated $2.5 million for fiscal years after 1987.

Effective date.—Enactment.

Conference agreement

(a) *Training and Technical Assistance.*—The conference agreement includes the Senate amendment, with an amendment requiring the Secretary to establish a 3-year demonstration project with a private or public nonprofit agency or organization for the purpose of training volunteers.

(b) *Powers of the Secretary.*—The conference agreement includes the Senate amendment, with a modification that deletes the au-

thority of the Secretary to prescribe rules and regulations deemed necessary to carry out the provisions of this section.

(c) *Employment of Volunteers.*—The conference agreement includes the Senate amendment.

(d) *Authorization of Appropiations.*—The conference agreement includes the Senate amendment, with an amendment authorizing appropriations, in appropriate parts from the HI and the SMI trust funds for fiscal years 1989, 1990, and 1991, such sums as may be necessary to conduct the demonstration project.

Effective date.—The conference agreement is effective for calendar years 1989, 1990 and 1991.

22. Case Management Demonstration Projects (Section 16 of Senate amendment)

Present law

"Case management" is a system under which a designated person or organization has responsibility for overseeing health care services for individuals assigned to the person or organization. Where case management is used, an insurer usually will not pay (or will pay less) for those services that are provided without permission of the case manager. Under current law, there are no requirements for Medicare beneficiaries to receive case management services, and case management is not a covered service under Medicare. Utilization and quality control peer review organizations (PROs) are responsible for reviewing the necessity and quality of services for Medicare beneficiaries.

House bill

No provision.

Senate amendment

(a) Description of Projects.—Requires HHS to establish not less than six demonstration projects under which a PRO agrees to provide case management services to Medicare beneficiaries with selected catastrophic illnesses.

(b) Purpose of Projects.—Specifies that the purpose of the demonstrations is to provide the Secretary and Congress with the information necessary (1) to evaluate the appropriateness of providing case management services under Medicare for individuals with catastrophic illnesses, and (2) to determine the most effective approach to implementing a case management system under the program for such individuals.

(c) Agreement.—Requires the agreement with the PRO to specify (1) the catastrophic illnesses for which case management services will be provided, (2) the payments to be made to the PRO for carrying out the project, and (3) such other terms and conditions as the Secretary and the PRO may agree to.

(d) Waivers.—Requires the Secretary to waive any provisions of Part B of title XI (relating to general provisions and Peer Review) and title XVIII of the Social Security Act (relating to Medicare) that the Secretary determines would prevent the establishment of a demonstration project under this provision.

(e) Duration.—Provides that the demonstration projects shall be conducted for a 1-year period. The Secretary may terminate the project before the end of the year if he determines that the State conducting the project is not in substantial compliance with the terms of the agreement with the PRO.

(f) Information and Reports.—(A) Requires a PRO with an agreement under section (a) to provide the Secretary with such information as the Secretary determines to be needed to evaluate the results of the project conducted by the PRO. (B) Requires the Secretary to submit an interim report based on information derived from the first 6 months of project operations, containing the findings, recommendations and conclusions of the evaluation of the project as described above.

(g) Authorization to Use Certain Funds.—Requires the Secretary to transfer from the HI and SMI trust funds amounts not to exceed $2 million to carry out the demonstration projects. Provides that amounts are to be transferred without regard to amounts appropriated in advance in appropriation acts. Requires payments from the trust funds to be made in such amounts as the Secretary determines to be fair and equitable.

Effective date.—Requires the Secretary to have the demonstrations in place 12 months after enactment. The interim reports are due 6 months from the date on which the demonstrations are initiated.

Conference agreement

(a) *Description of Projects.*—The conference agreement includes the Senate amendment, with an amendment requiring the Secretary to establish 4 demonstration projects under which an appropriate entity agrees to provide case management services to Medicare beneficiaries with selected catastrophic illnesses, particularly those with high costs of health care services. A further amendment requires that at least one of the demonstration projects be conducted by a peer review organization (PRO).

(b) *Purpose of Projects.*—The conference agreement includes the Senate amendment, with an amendment that the demonstration projects are to evaluate the appropriateness of, and determine the most effective approach of, providing case management services for Medicare beneficiaries with high costs of medical care.

(c) *Agreement.*—The conference agreement includes the Senate amendment, with an amendment that the demonstration project agreements must specify the high cost cases to which case management services will be provided.

(d) *Waivers.*—The conference agreeement includes the Senate amendment, with an amendment requiring the Secretary to waive (in addition to provisions of Part B of Title XI of the Social Security Act) any of Medicare's limitations or restrictions on benefits necessary to conduct the demonstration projects.

(e) *Duration.*—The conference agreement includes the Senate amendment, with an amendment that the data collection phase of the demonstration projects will be conducted for a 2-year period, with an additional period of time to write the report and submit it to Congress.

(f) *Information and Reports.*—The conference agreement includes the Senate amendment, with an amendment that the interim report will be based on information derived from the first year of project operations, and the final report will be based on data derived from the projects.

(g) *Authorization to Use Certain Funds.*—The conference agreement includes the Senate amendment, with an amendment requiring the Secretary to transfer, from the HI and the SMI trust funds in proportions the Secretary determines are appropriate, an amount not to exceed $2,000,000 in each of 2 years for administrative costs to carry out the demonstration projects.

Effective date.—The conference agreement requires the Secretary of HHS to establish the demonstration projects within 12 months after the date of enactment.

23. Changes in Certification of Medicare Supplemental Health Insurance Policies (Section 209 of House bill; Section 13 of Senate amendment)

Present law

(a) Establishment of New Medigap Standards.—Under section 1882 of the Social Security Act, insurers who market private insurance policies to fill the gaps in Medicare's coverage may have the policies certified as Medicare supplemental health insurance policies by the Secretary if the policies meet minimum standards. These standards were developed and approved by the National Association of Insurance Commissioners (NAIC) on June 6, 1979, and are incorporated by reference in section 1882 of the Social Security Act. Policies that are certified by the Secretary may be marketed as Medicare supplemental policies. However, if a State has adopted laws and/or regulations at least as stringent as those of the NAIC, policies regulated by the State are deemed to meet Federal requirements.

(b) Required Mailing of Notice.—Section 1882 (e) requires the Secretary to provide to individual Medicare beneficiaries information that will permit them to assess the value of the Medicare supplement policies to them and the relationship of any such policies to benefits under the Medicare program.

(c) Required Submission of Advertising.—There is currently no Federal requirement that insurance companies submit their Medigap advertisements for review to the State Commissioners of Insurance.

(d) Transition for Current Policies.—There is no present law relating to transition periods for current Medigap policies.

(e) Free Look Period.—Under the existing NAIC standards, Medigap policies are required to provide a "free look" period of 10 days for policies sold by mail, during which a policyholder may return the policy and get a full refund of any premium paid.

(f) Reporting of Information Relating to Loss Ratios.—Section 1882(b)(1) provides for loss ratio targets for Medicare supplemental policies that set a goal for the percentage of insurance premiums that must be returned to policyholders in the form of benefits. Medigap policies must be expected to pay benefits at least equal to 60

percent of the earned premiums for individual policies and 75 percent for group policies.

House Bill

(a) Establishment of New Medigap Standards.—

(1) Requires the Secretary to report to Congress not later than 150 days after the date of enactment of this act, on changes that should be made in the requirements of section 1882(c) of the Social Security Act for certification of Medicare supplemental policies to take into account the changes made by this act, and by any other pertinent acts enacted by the first session of the 100th Congress, and by any recommendations developed by the NAIC;

(2) Expresses the sense of Congress that: (A) Congress will promptly act on such recommendations and provide for appropriate changes in the requirements of 1882(c), and (B) States will be expected to adjust their laws in a timely manner to comply with changes in such requirements.

(b) Required Mailing of Notice.—Adds a new provision to section 1882 requiring that in order to meet the requirements for certification as a Medicare supplementary insurance policy, a policy offered in a State and in effect on January 1, 1988 must send a letter by January 31, 1988 to its policyholders who are entitled to Medicare, explaining: (a) the improved benefits resulting from this and other legislation enacted by the first session of the 100th Congress and (b) how these improvements affect the benefits contained in these policies and the premiums for these policies. Applies to Medicare supplemental policies as of February 1, 1988.

(c) Required Submission of Advertising.—Amends section 1882(b) to require that entities issuing Medigap policies submit their advertisements (whether through written, radio or television medium) used (or, at the option of the State, to be used) for the policy in the State, to the State Commissioner of Insurance for his or her review in accordance with State law.

(d) Transition for Current Policies.—

(1) Suspends (with the exception of Medigap policies sold in States described in (2) below) from January 1, 1988 through December 31, 1988, current Federal penalties under section 1882 for selling policies to Medicare beneficiaries which (a) were sold before the date of the enactment of this act, and (b) would not substantially duplicate health benefits to which they are otherwise entitled under Medicare but for the changes made by this act.

(2) Gives additional time to certain States (to be identified by the Secretary) in which penalties will be suspended. These are States which require legislation (other than legislation appropriating funds) in order for Medicare supplemental policies to be changed to avoid a penalty under section 1882, but the legislature of the State is not scheduled to meet in the 1988 legislative session in which such legislation may be considered. The exception in these States extends to the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after Jan-

uary 1, 1989, for which legislation described above may be considered.

(e) Free Look Period.—No provision.

(f) Reporting of Information Relating to Loss Ratios.—No provision.

Effective dates.—Enactment, except that (b) regarding notices to beneficiaries applies to Medicare supplemental policies as of February 1, 1988, and (c) applies to such policies with respect to advertising used on or after January 1, 1988.

Senate amendment

(a) Establishment of New Medigap Standards.—Amends section 1882 by making conforming changes and adding a new provision relating to NAIC amendments of its model regulation of Medicare supplemental (Medigap) policies to reflect the changes in law made by this Act:

(1) Provides that if the NAIC revises the existing model standards for Medigap policies within 90 days after enactment, then those standards will apply as the standard for certification, beginning 1 year later.

(2) Specifies that if the NAIC does not amend the standards within 90 days, the Secretary is required to issue Federal model standards for Medigap policies reflecting the changes in law made by this act, within 90 days, to become effective 1 year later.

(3) Specifies that no Medigap policy may be certified by the Secretary, no certification shall remain in effect and no State regulatory program will be found in compliance with Section 1882, unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set forth in the amended NAIC Model Regulation or the Federal model standards (as the case may be).

(b) Required Mailing of Notice.—Amends Section 1882(e) to require the Secretary to: (a) inform Medicare beneficiaries (and, to the extent feasible, individuals about to become entitled to Medicare) about current laws that prohibit certain marketing and sales abuses and the manner in which they may report any such action or practice to an appropriate official of HHS and (b) establish a toll-free telephone number for individuals to report suspected violations of the laws relating to Medigap standards. Also requires the Secretary to provide Medicare beneficiaries with a listing of the addresses and telephone numbers of State and Federal agencies and offices where information and assistance relating to Medicare supplemental policies may be obtained.

(c) Required Submission of Advertising.—No provision.

(d) Transition for Current Policies.—No provision.

(e) Free Look Period.—Section 1882(b)(1) is amended to require a uniform 30-day free look period for all Medicare supplemental policies, without regard to the manner in which the purchase of the policy was solicited.

(f) Reporting of Information Relating to Loss Ratios.—Amends section 1882(b)(1) to provide that information with respect to the actual ratio of benefits provided to premiums collected under Medigap policies will be reported to the State on forms conforming to

those developed by the NAIC for such purpose, or such ratios will be monitored under the program in an alternative manner approved by the Secretary.

Effective dates.—(a) is effective as provided in the amendment; (b) enactment; changes made by (e) and (f) are effective on the date on which the amended NAIC Model Standards (or Federal Model Standards) become effective under section 1882.

Conference agreement

(a) *Establishment of New Medigap Standards.*—The conference agreement includes the Senate amendment with amendments. The agreement provides for a procedure whereby the current National Association of Insurance Commissioner's (NAIC) model regulation would be amended or replaced as a standard for certification of Medicare Supplemental Insurance Policies. If the NAIC amends the model regulations within 90 days of enactment of this bill, in accordance with requirements in this section then the amended standards would apply as a standard for certification.

The NAIC has made available to the conferees both a model transition regulation, adopted in September 1987 in anticipation of the passage of this bill, and a draft of a new model minimum standards regulation. The conferees believe the transition regulation deals appropriately with the matter of adapting existing, certified policies to the amendments in Medicare made under this Act. The conferees also believe the draft model minimum standards regulation includes many appropriate provisions. The conferees intend and understand that the revised standards will continue to incorporate such provisions, including rules governing matters covered in the existing and draft model standards, such as minimum benefit standards, loss ratios, disclosure requirements and replacement requirements.

The conferees note that the NAIC model transition regulation contains an explicit prohibition on the inclusion of provisions in Medicare supplemental policies which duplicate the benefits covered under Medicare. The conferees believe such an explicit prohibition clarifies the meaning of the current requirements of Section 1882 that supplemental policies may not duplicate Medicare coverage. This amendment requires that the model standards include provisions otherwise necessary to reflect changes in law made by this Act. In enacting this provision, the conferees intend and understand that NAIC will include a similar provision precluding insurers from selling or maintaining Medicare supplemental policies which provide benefits covered by this Act in its final version of the model minimum standards regulation.

The conferees note in particular that Section 5B of the NAIC Transition Regulations provides for (1) a notice to the beneficiary, (2) the filing by the insurer of riders to the policy to eliminate duplication, and (3) the making of an appropriate refund or appropriate premium adjustment for duplicative coverage. The conferees intend and understand that such provisions will be included in the final model regulations. The conferees intend and understand that such appropriate refund or premium adjustments are to be made retroactive to the effective date of the new Medicare benefits enacted in this bill.

The conferees are particularly concerned about beneficiaries not paying for benefits under Medicare supplemental insurance policies that duplicate benefits covered under this Act. The conferees intend not merely to prevent such duplicative coverage from occurring, but also that beneficiaries receive appropriate premium adjustments where this has occurred.

If NAIC does not amend the regulations within 90 days, then the Secretary is directed to promulgate Federal model standards for certification of Medicare supplemental policies to reflect the changes in law made by this Act. Such Federal standards would then be the standards for certification. The conferees intend that such standards would incorporate all matters provided for in the bill and discussed above in this report with respect to the NAIC model standards.

The NAIC model standards (or the Federal model standards, as the case may be) would apply in a State effective on the earlier of (1) the date the State adopts standards equal to or more stringent than the amended NAIC standards (or the Federal standards), or (2) one year after the NAIC (or the Secretary, in the case of Federal standards) first adopts the standards.

The conference agreement also provides that the Secretary, rather than the President, will appoint the four State Commissioners or superintendents of insurance who, together with the Secretary, form the Supplemental Health Insurance Panel.

The conferees note that under this legislation, Medicare coverage of outpatient prescription drugs will begin in January 1991. The conferees do not intend for the enactment of this drug benefit to be construed as requiring current Medicare supplemental policies, which do not otherwise provide coverage for drugs to begin doing so upon enactment. Under the conference agreement, the NAIC (or the Secretary, as the case may be) will determine whether coverage of the drug deductible should be required for certification as a Medicare-certified policy.

(b) *Required Mailing of Notice.*—The conference agreement includes both the House provision and the Senate amendment, with modifications. In States which have enacted the NAIC Transition Regulations, beneficiaries will receive notices from insurers pursuant to the requirements of those regulations. In States which have enacted the final model standards, but not the transition regulations, insurers must send notices to beneficiaries in accordance with the requirements of this provision in order to remain certified. In States which have enacted neither the final model nor the transition regulations, insureers must follow the requirements described in (d) below. The House provision is modified to change each 1988 date to 1989. The Senate amendment is modified to require the Secretary (1) to inform Medicare beneficiaries of how they may report any marketing or sales abuses to HHS or to an appropriate State official, and (2) to publish the toll-free HHS telephone number for individuals to report suspected violations.

(c) *Required Submission of Advertising.*—The conference agreement includes the House provision, with a modification clarifying that the submission of advertisements to the State Commissioner of Insurance (or comparable officer identified by the Secretary) should

be in accordance with review or approval as required under State law.

(d) *Transition for Current Policies.*—The conference agreement includes the House provision with amendments. The agreement does not include the provision which waives Federal penalties for knowingly selling policies with duplicative coverage. The agreement provides for the opportunity to sell or maintain certified Medicare supplemental health insurance policies during the period after enactment of the bill in those States which have not adopted standards by January 1, 1989 to reflect the changes in law made by this Act. The agreement provides that for policies sold prior to enactment (but in effect after enactment), a policy is deemed non-duplicative and may be deemed certified in the insurer selling the policy complies with the NAIC Model Transition Regulation by January 1, 1989, as discussed below. For policies sold after the date of enactment, such compliance would be required before the date of sale of the policy.

The conferees specifically intend that as a matter of Federal law, effective January 1, 1989 (for existing policies) or prior to sale (for policies later sold), Medicare supplemental insurance policies no longer include benefits that are provided for under this Act. Further, the conferees intend, that as a matter of Federal law, effective January 1, 1989, insurers whose policies would contain duplicate coverage but for such provision, notify the insured of such change in coverage, of any resulting premium refunds or adjustments, and when such refunds or adjustments will be made. The notice shall include the matters contained in Section 5(B)(1)(a), (b), and (c) of the NAIC model transition regulations and shall be mailed on the later of January 1, 1989 or the date the policy is sold. For this purpose, the insurer would not have to comply with the requirement of Section 5(B) that the notices be in a form approved by the State Insurance Commissioner.

Further, the conferees intend that insurers are required to take all necessary steps to effectuate such refunds or premium adjustments in the most expeditious possible manner, including immediately filing any appropriate riders to insurance policies. The conferees specifically intend and understand that all such appropriate refunds or premium adjustments will be made retroactive to January 1, 1989 or the date on which the policy is sold, whichever is earlier.

The conferees understand that insurers offering policies which are guaranteed renewable will conform their policies to prevent duplication of coverage in accordance with the provisions in this Act.

The conference agreement also requires the Secretary to report to Congress in March 1989 and in July 1990 on actions States have taken in adopting standards equal to or more stringent than the NAIC Model Transition Regulation or the amended NAIC model regulation (or Federal model standards).

(e) *Free Look Period.*—The conference agreement includes the Senate amendment.

(f) *Reporting of Information Relating to Loss Ratios.*—The conference agreement includes the Senate amendment.

(g) Prohibiting Misuse of Social Security or Medicare References.—The Conference agreement prohibits the use of the word "Social Security", "Social Security Account", "Social Security

System", "Social Security Administration", "Medicare", "Health Care Financing Administration", or any acronym, combination, or variation of such words, and any symbols or emblems of such agencies, in a manner which a person or an organization knew or should have known would convey the false impression that any advertisement or other item is authorized by the Social Security Administration, the Health Care Financing Administration or the Department of Health and Human Services.

The conference agreement authorizes the Secretary to impose civil money penalties of not more than $5,000, or $25,000 in the case of a broadcast or telecast, for violations of this prohibition. The total amount of penalties imposed for multiple violations consisting of substantially identical communications or productions could not exceed $100,000 a year. Those who are assessed penalties would be permitted to request a hearing before an Administrative Law Judge and to appeal thereafter to the U.S. District Court of Appeals. In assessing fines and pursuing violators, the Secretary would be required to coordinate his actions with the Justice Department.

The conferees intent that, to the extent feasible, the Secretary would use informal methods to deal with potential violations prior to initiating action under this provision. Such methods might include a letter which identifies a violation or which points out that the addition of a conspicuously-placed disclaimer of affiliation with the Social Security Administration could avoid the need for action under this provision.

The conferees also intend that the authorities established by this provision should supplement, not substitute for, existing authority of the U.S. Postal Service to take action against misleading and fraudulent references to the Social Security Administration in materials which re mailed.

(h) *Civil Money Penalties for Medigap Violations.*—The conference agreement authorizes civil montary penalties, in every case where only criminal penalties currently apply, for deceptive selling practices relating to Medicare supplemental health insurance (medigap) policies. Violations would be subject to a civil monetary penalty of up to $5,000 per violation.

Effective date.—The conference agreement provides that (a) applies as provided in the section and the Secretary is required to provide for the reappointment of members of the Supplemental Health Insurance Panel by not later than 90 days after the date of enactment. The provisions of (b) requiring the Secretary to provide consumer information apply on enactment; and the provision of (b) requiring health insurers to send informational letters to their policy holders apply to Medicare supplemental policies as of January 31, 1989. (c) applies to Medicare supplemental insurance policies as of Janaury 1, 1989, with respect to advertising used on or after such date. (d) applies as provided in the section. (e) and (f) apply on the date the amended NAIC Model Standards (or Federal model standards) become effective under Section 1882 of the Social Security Act. (g) and (h) are effective on enactment and apply only with respect to violations occurring after enactment.

24. Research on Long-Term Care Services for Medicare Beneficiaries (Section 211 of House bill; Section 15 of Senate amendment)

Present law

(a)–(b) Long-Term Care Services.—Medicare does not cover services required for individuals whose chronic conditions require long-term nursing home or home and community-based services. There is no current requirement that the Secretary provide for research relating to long-term care services nor is there any specific authorization for appropriations for such research.

(c) Institute of Medicine Study.—There is no current requirement that the IOM conduct a study on the financing of long-term care.

(d) Treasury Department Study of Tax Incentives for Long-Term Care.—There is no current requirement that the Secretary of Treasury conduct a study on the financing of long-term care. The President has asked the Department of Treasury to review tax policy as it affects the provision of catastrophic and long-term care health insurance.

House bill

(a) Health and Human Services Study.—Requires the Secretary to provide for research relating to the delivery and financing of long-term care services for Medicare beneficiaries. It shall include at least the following: (1) the financial characteristics of Medicare beneficiaries who receive or need long-term care services, including whether beneficiaries are eligible for Medicaid benefits for such services; (2) how financial and other characteristics of Medicare beneficiaries affect their utilization of institutional and noninstitutional services; (3) how relatives and Medicare beneficiaries are affected financially and in other ways because the beneficiaries require or receive long-term care services; (4) the quality of long-term care services (in community-based and custodial settings) and how the provision of such services may reduce expenditures for acute health care services; (5) the effectiveness of, and need for, State and Federal consumer protections which assure adequate access to and protect the rights of beneficiaries provided long-term care (other than in a nursing facility).

Defines long-term care services to include nursing home care, home care, community-based services, and custodial care.

(b) Authorization of Appropriations.—Authorizes to be appropriated, in equal parts from the HI and SMI trust funds, $5 million for each of fiscal years 1988, 1989, 1990, 1991, and 1992, to carry out the research described in (a).

(c) Institute of Medicine Study.—No provision.

(d) Treasury Department Study of Tax Incentives for Long-Term Care.—No provision.

Effective date.—Enactment.

Senate amendment

(a) Health and Human Services Study.—No provision.

(b) Authorization of Appropriations.—No provision.

(c) Institute of Medicine Study.—

(1) Requires the Secretary to request the National Academy of Sciences, through the Institute of Medicine (IOM), to contract for an IOM study to (a) explore options for private funding of a portion of long-term care (including methods by which changes in Federal laws, including tax laws, could facilitate such funding) and determine whether such options would be effective as compared to public financing alternatives and would be beneficial to the broad spectrum of populations (including children and adults who have attained and have not attained retirement age) requiring protection; (b) analyze the effect that provision of types of private funding of long-term care would have on public funding of such care; (c) review options for public sector coverage, both means-tested and universal, with respect to their effects on current and future Federal spending for health care; (d) review the effectiveness, quality of life provided, effect on family caregivers, and cost-implications of community-based long-term care, including types of limits necessary to assist beneficiaries and providers in preventing overutilization; (e) analyze, for each approach to provision of care, relative payments derived from users, non-utilizing elderly and employed persons (including both pre-funding and pay-as-you-go); and (f) review sources of financing and coverage of long-term care services in other developed nations and the implications of these findings on the development of similar policies in the United States.

(2) Requires the IOM study to take into account (a) the effect that impending demographic changes (near and long-term) will have on various approaches to service utilization and funding; (b) the impact of the various approaches to funding, both public and private, on access to long-term care services by individuals of all age groups (including children and adults who have attained and not attained retirement age), individuals of different socioeconomic and minority groups, and women; and (c) the effect that membership in these different groups has on the need, the ability to pay, and access to quality long-term care.

(3) Requires the Secretary to enter into appropriate arrangements with the Academy under which the Secretary will be responsible for expenses incurred for the study. Requires the Secretary to transfer from the HI and SMI trust funds amounts necessary to fund the study.

(4) Requires IOM to submit, by October 1, 1989 to the Secretary, the Senate Finance Committee and the House Energy and Commerce and Ways and Means Committees, a report that describes the study, includes a statement of the data obtained, and specifies administrative actions and changes in law that IOM considers to be appropriate to implement the study findings.

(d) Treasury Department Study of Tax Incentives for Long-Term Care.—Requires the Secretary of Treasury to conduct a study of Federal tax policies to promote the financing of long-term care. The study shall identify alternative methods of creating tax incentives to encourage individuals to purchase insurance for long-term care. Requires the study to consider also the cost to the U.S. Treas-

ury and the potential benefits to consumers, including whether the incentives would benefit all or most of the population requiring protection. Requires Secretary to consult with representatives of the insurance industry, providers of long-term care, and consumers. Requires the Secretary to report the results of the study and make recommendations to the Congress prior to April 1, 1988 of any changes in Federal law that the Secretary determines to be appropriate to promote financing of long-term care. Defines long-term care to include care and services provided by nursing homes, home health agencies and other mechanisms for long-term care delivery.

Effective date.—Enactment.

Conference agreement

(a) *Health and Human Services Study.*—The conference agreement includes the House provision with amendments. To the extent possible, the Secretary is to rely on research that has already been conducted or is underway by the Health Care Financing Administration or the National Center for Health Services Research and Health Care Technology (in their National Medical Expenditures Survey). The Secretary is required to submit interim reports by December 1990 and December 1992, and a final report by June 1994 to the House Committees on Energy and Commerce and Ways and Means, and the Senate Finance Committee describing the findings of the long-term care research required by this provision.

(b) *Authorization of Appropriations.*—The conference agreement includes the House provision.

(c) *Institute of Medicine Study.*—The conference agreement does not include the Senate amendment. The conferees note that the Secretary may contract with the Institute of Medicine to conduct the research required by Section 211(a) of the House provision.

(d) *Treasury Department Study of Tax Incentives for Long-Term Care.*—The conference agreement includes the Senate amendment, with an amendment that reporting date be changed to November 31, 1988.

Effective date.—The conference agreement is effective on enactment.

25. Study of Adult Day Care Services (Section 212 of House bill; Section 24 of Senate amendment)

Present law

Medicare does not provide coverage for adult day care services.

House bill

(a) Survey of Current Adult Day Care Services.—Requires the Secretary to survey adult day care services to collect information on (1) the scope of such services and the extent of their availability; (2) the characteristics of entities providing such services; (3) licensure, certification and other quality standards that are applied to those providing such services; (4) the cost and financing of such services; and (5) the characteristics of the people who use such services.

Defines adult day care services as medical or special services provided in an organized nonresidential setting to chronically impaired persons who are not inpatients in a medical institution.

(b) Report.—Requires the Secretary to report to Congress, within one year after enactment, on the information collected in the survey. Requires the report to include recommendations concerning appropriate standards for adult day care services under Medicare, including definitions of chronically dependent individuals and services in adult day care, establishing qualifications of providers of adult day care services, and establishing a reimbursement mechanism.

Effective date.—Enactment.

Senate amendment

(a) Survey of Current Adult Day Care Services.—Identical provision.

(b) Report.—Identical provision.

Effective date.—Enactment.

Conference agreement

(a) *Survey of Current Adult Day Care Services.*—Identical provision.

(b) *Report.*—Identical provision.

Effective date.—The conference agreement is effective on enactment.

26. U.S. Bipartisan Commission on Comprehensive Health Care (Sections 401-408 of House bill; Section 30 of Senate amendment)

Present law

No provision.

House bill

(a) Establishment/Duties.—Establishes a commission to be known as the U.S. Bipartisan Commission on Comprehensive Health Care. Requires that the Commission: (1) examine short-comings in the current health care delivery and financing mechanisms that limit or prevent access of all individuals to comprehensive health care; and (2) make specific recommendations to Congress on Federal programs, policies, and financing needed to assure the availability of comprehensive long-term care services for the elderly and disabled, comprehensive health care services for the elderly and disabled, and comprehensive health care services for all individuals in the United States. Requires the Commission to consider as it makes its recommendations: (1) the amount and sources (consistent with principles of social insurance) of Federal funds to finance the needed services, including reallocations of existing Federal program funds; and (2) the most efficient and effective manner of administering these programs.

Defines "comprehensive health care services" as including: (1) inpatient hospital services (including mental health services); (2) skilled nursing facility services, intermediate care facility services, home health services, and other long-term care services; (3) physician services and other outpatient health care services (including

mental health services); (4) periodic general physical examinations; eye, hearing, dental, and foot examinations; and other preventive health care services; and (5) prescription drugs, eye-glasses, hearing aids, orthopedic equipment, and dentures (both complete and partial).

Defines "comprehensive long-term care services" as including custodial and noncustodial services in facilities, as well as home and community-based services.

(b) Membership.—Requires that the Commission be composed of 15 members appointed as follows: (1) the President will appoint 3 members; (2) the President Pro Tempore of the Senate will appoint, after consultation with the minority leader of the Senate, 6 Members of the Senate, of whom not more than 4 may be of the same political party; and (3) the Speaker of the House will appoint, after consultation with the minority leader of the House, 6 Members of the House, of whom not more than 4 may be of the same political party. The Commission will elect a chairman and vice chairman from among its members. Any vacancy in the membership of the Commission will be filled in the manner in which the original appointment was made and will not affect the power of the remaining members to execute the duties of the Commission.

(c) Meetings.—Specifies that the Commission will meet at the call of its chairman or a majority of its members; a quorum will consist of 8 members, except that 4 members may conduct a hearing. Members of the Commission may not receive compensation but may be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Commission.

(d) Staff.—Provides that the Commission may appoint and determine the compensation of staff, and may procure the temporary and intermittent services of consultants necessary to carry out the duties of the Commission.

(e) Powers.—Provides that the Commission may hold hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties. The provision requires, upon request of the Commission: (1) the Comptroller General to conduct studies or investigations; (2) the Director of the Congressional Budget Office to provide cost estimates; (3) the head of a Federal agency to provide technical assistance; and (4) the Administrator of General Services to provide on a reimbursable basis administrative support services, which the Commission determines to be necessary to carry out its duties. The head of any Federal agency may detail to the Commission, without reimbursement, any personnel to assist the Commission in carrying out its duties. The Commission is authorized: (1) to use the U.S. mails; (2) to secure directly from any Federal agency information that may be disclosed to enable the commission to carry out its duties; and (3) to accept, use and dispose of gifts or donations of services or property.

(f) Reports.—

(1) Requires the Commission to submit not later than 6 months after enactment a report to Congress on its findings and recommendations regarding comprehensive long-term care services for the elderly and disabled. The report is to include detailed recommendations for appropriate legislative initiatives.

(2) Requires the Commission to submit not later than 1 year after enactment a report to Congress on its findings and recommendations regarding comprehensive health care services for the elderly and disabled and for all individuals in the United States. The report is to include detailed recommendations for appropriate legislative initiatives.

(g) Termination.—Specifies that the Commission shall terminate 30 days after the date it submits its report on comprehensive health care services.

(h) Authorization.—Authorizes $1.5 million for the Commission.

Effective date.—Enactment.

Senate amendment

(a) Establishment/Duties.—Identical provision.
(b) Membership.—Identical provision.
(c) Meetings.—Identical provision.
(d) Staff.—Identical provision.
(e) Powers.—Identical provision.
(f) Reports.—Identical provision.
(g) Termination.—Identical provision.
(h) Authorization.—Identical provision.
Effective date.—Enactment.

Conference agreement

Identical provision.

Effective date.—The conference agreement is effective on enactment.

27. Extension of Social HMO Demonstration Project (Section 210 of House bill)

Present Law

Section 2355 of DEFRA of 1984 (P.L. 99-369) required the Secretary to approve Medicare and Medicaid waivers needed to implement a demonstration project for social health maintenance organizations (SHMOS). These organizations are to provide an integrated package of health, long-term care, and social services on a prepaid capitation basis for persons who voluntarily enroll with the organization. There are currently four demonstration projects.

There is a comparable provision in section 4079 of Public Law 100-203.

House bill

Requires the Secretary to extend, without interruption, through September 30, 1992, the approval of waivers granted under Section 2355 of DEFRA of 1984 for the SHMO demonstration projects described in that provision, subject to the same terms and conditions (other than the duration of the project) established under that provision. It amends section 2355(b)(5) of DEFRA relating to Medicare's risk contract with the HMO to state that all payors will share risk for no more than 2 years, with the organization being at full risk in the 3rd year and in succeeding years. It requires the Secretary to send an interim report to Congress by December 1988

(rather than a final report, as in current law), and it requires the Secretary to submit a final report not later than March 31, 1993.

Effective date.—Enactment.

Senate amendment

No provision.

Conference agreement

The conference agreement does not include the House provision. A comparable provision was enacted in Section 4079 of P.L. 100-203.

28. Protection of Medicare Beneficiaries Enrolled in an Eligible Organization With a Risk-Sharing Contract Against Certain Practices (Section 10A of Senate amendment)

Present law

(a) Notice to Medicare Beneficiaries.—No provision.

(b) Civil Monetary Penalties and Intermediate Sanctions Against HMOs/CMPs.—HMOs/CMPs must provide assurances to the Secretary that they will not expel or refuse to reenroll any individual on the basis of health status or need for health services.

For each instance in which an HMO/CMP fails substantially to provide medically necessary items and services to a beneficiary, the Secretary may impose a $10,000 civil monetary penalty. No other sanctions short of contract termination are available for most other kinds of possible HMO/CMP contract or legal violations.

(Similar provision included in Omnibus Budget Reconciliation Act of 1987, except does not provide for refund to enrollee of excess charge and does not include extra $15,000 penalty for each individual not enrolled as a result of improper marketing practices.)

House bill

No provison.

Senate amendment

(a) Notice to Medicare Beneficiaries.—Requires an HMO or CMP with a Medicare risk-sharing contract to notify enrolled beneficiaries and potential enrollees that the organization may legally terminate or refuse to renew the contract, and that beneficiaries' enrollments may be terminated if this should occur. The notice would be included in any promotional materials furnished to potential enrollees and in information provided to all enrollees at the time of enrollment and annually thereafter. (Identical provision included in Omnibus Budget Reconciliation Act of 1987).

(b) Civil Monetary Penalties and Intermediate Sanctions Against HMOs/CMPs.—Increases the civil monetary penalty for failure to furnish medically necessary services to $25,000 for each failure. Provides for additional civil monetary penalties as follows:

(a) For each case in which an enrollee is charged a premium greater than permitted by law, $2,000 plus double the amount of the excess charge. The excess charge would be deducted from the penalty and returned to the enrollee.

(b) For each case in which the HMO/CMP expels or refuses to reenroll a beneficiary on the basis of health status, $15,000.

(c) For engaging in any practice which could reasonably be expected to result in denying or discouraging enrollment on the basis of health status, $100,000, plus $15,000 for each individual not enrolled as a result.

(d) For each case in which the HMO/CMP falsifies or misrepresents enrollment information furnished to the Secretary, any individual, or any other entity, or enrolls an individual without consent, or gives an individual a material inducement to enroll, $15,000. The penalty for each instance of false enrollment information furnished to the Secretary would be $100,000.

Provides that, in addition to or instead of imposing civil penalties, the Secretary may after notice to the organization suspend new enrollments or suspend payments to the HMO/CMP on behalf of new enrollees. Incorporates existing provisions on administration of civil monetary penalties.

Effective date.—(a) Applies to contracts entered into or renewed on or after the date of enactment.

(b) Becomes effective at the end of the 14 day period beginning on the date of enactment and does not apply to administrative proceedings commenced before the end of such period.

Conference agreement

The conference agreement includes the Senate amendment, with modifications. Only provisions not already enacted in the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203) are included. Excess premium charges collected from enrolleees are to be refunded, and an organization may be subject to a $15,000 civil monetary penalty for each case in which it expels or refuses to reenroll a beneficiary on the basis of health status.

29. Repeal of Authority to Administer Proficiency Examinations (Section 17 of Senate amendment)

Present law

Section 1123 of the Social Security Act allows the use of a testing program to determine the proficiency of individuals who desire to become skilled medical technicians. In the conduct of such tests, no individual who otherwise meets the proficiency requirements for the health care specialty can be denied a satisfactory proficiency rating solely because of his failure to meet formal educational or professional membership requirements. Currently, persons who are judged proficient as a result of this test may avoid going through an accredited education program designed to train such personnel.

House bill

No provision.

Senate amendment

Repeals section 1123, effective October 1, 1987. Provides that the repeal would not affect the authority of the Secretary to conduct the program established under 1123 prior to October 1, 1987 or the

qualification of individuals to perform their duties and responsibilities who were certified by reason of previously administered exams.

Effective date.—October 1, 1987.

Conference agreement

The conference agreement includes the Senate amendment. The conferees note that this authority had already expired on September 30, 1987.

Although the authority would have allowed the Secretary to develop proficiency examinations for a variety of health personnel, the only examinations ever administered were those for clinical laboratory personnel. The conferees have been advised that there may develop a shortage of such personnel in the future. If this occurrs, the conferees anticipate that consideration could be given to the appropriateness of authorizing a new examination for such personnel.

Effective date.—The conference agreement is effective October 1, 1987.

30. Study and Reports by the Office of Personnel Management on Offering Medicare Supplemental Plans to Federal Medicare Eligible Individuals, and Other Program Changes (Section 23 of Senate amendment)

Present law

(a) Study and Report.—Under the Federal Employees Health Benefits (FEHB) Program, Federal employees and annuitants and their dependents are offered health benefits coverage from a range of participating health benefit plans. Since the FEHB program offers no plans that only supplement Medicare's coverage, the benefits available under the plans in the FEHB program duplicate certain benefits under the Medicare program.

(b) Feasibility Study and Report.—Under Section 1882 of the Social Security Act, the Secretary is required to establish a procedure by which Medicare supplemental policies may be certified by the Secretary as meeting minimum standards and requirements if they meet or exceed certain model standards developed and adopted by the National Association of Insurance Commissioners and meet certain loss ratio requirements. If a State establishes a regulatory program that provides for the application of these same minimum standards and requirements to Medicare supplemental policies, then such policies issued in that State are deemed to have met the requirements under the Secretary's certification program.

Section 1882 defines Medicare supplemental policies as health insurance policies or other health benefits plans offered by a private entity to individuals covered by Medicare that supplement Medicare's coverage; policies or plans of one or more employers or labor organizations are not included in this definition.

House bill

No provision.

Senate amendment

(a) Study and Report.—Requires the Director of the Office of Personnel Management (OPM), no later than April 1, 1989, to conduct a study and submit a report to the Senate Committee on Governmental Affairs and the House Committee on Post Office and Civil Service regarding changes to the Federal Employees Health Benefits Program that may be required to incorporate plans designed specifically for Medicare eligible individuals and to improve the efficiency and effectiveness of the program.

Prohibits any Medicare supplemental plan recommended by the Director of OPM from duplicating benefits for which payment is made under Medicare. However, any such recommended plan (1) must cover expenses that are not payable by Medicare because of deductible and coinsurance amounts, and (2) may offer additional reimbursement where Medicare benefits are limited by fee schedule and for benefits not covered by Medicare which may be of value to Medicare eligible individuals.

(b) Feasibility Study and Report.—Requires the Director of the Office of Personnel Management, no later than April 1, 1989, to report to the appropriate committees of Congress whether it is feasible to adopt such standards as issued by the National Association of Insurance Commissioners as required by section 1882 of the Social Security Act for Medicare supplemental policies, when providing Medicare supplemental plans as a type of health benefits plan available under the Federal Employees Health Benefits Program.

Effective date.—The reports required by (a) and (b) are due no later than April 1, 1989.

Conference agreement

(a) *Study and Report.*—The conference agreement includes the Senate amendment.

(b) *Feasibility Study and Report.*—The conference agreement includes the Senate amendment.

Effective date.—The conference agreement is effective upon enactment.

31. Rate Reduction For Medicare Eligible Federal Employees (Section 22 of Senate amendment)

Present law

Under the Federal Employees Health Benefits (FEHB) Program, Federal employees and annuitants and their dependents are offered health benefits coverage from a range of participating health benefit plans. The premiums for such coverage are shared by the Federal Government and by the enrollees. Premium payments are deposited in the Employees Health Benefits Fund, from which benefit and administrative costs are paid.

Since the FEHB Program offers no plans that only supplement Medicare's coverage, the benefits available under the plans in the FEHB Program duplicate certain benefits under the Medicare program.

House bill

No provision.

Senate amendment

Requires the Office of Personnel Management, in consultation with carriers offering health benefits plans under the Federal Employees Health Benefits Program, to reduce the rates charged to Medicare eligible individuals participating in such health plans by the amount, prorated for each covered Medicare eligible individual, of the estimated cost of medical services and supplies which would have been payable by such plans if the catastrophic coverage benefits (those in sections 2(a), 3(a), 4, and 7(b) of this bill) had not been enacted.

Defines "Medicare eligible individual" as any annuitant, survivor of an annuitant, or former spouse of an annuitant (1) who is otherwise eligible for benefits under the Federal Employees Health Benefits Program, eligible for benefits under Part A of Medicare, and covered by Part B of Medicare, and (2) for whom benefits paid under Medicare are the primary source of health care benefits.

Provides that funds in the Employees Health Benefits Fund for the Federal Employees Health Benefits Program are available without fiscal year limitation for costs incurred by the Office of Personnel Management in making such rate reductions.

Effective date.—Provides that the reduced rates apply as of the effective date of the Medicare catastrophic coverage (items and services furnished after, and premiums for months beginning after, December 31, 1987).

Conference agreement

The conference agreement includes the Senate amendment, with technical amendments to insure that all catastrophic benefits would be included in determining the rate reduction.

Effective date.—The conference agreement is for health benefit plans beginning January 1, 1989.

32. Maintenance of Effort (Section 21 of Senate amendment)

Present law

Many older, disabled and retired workers participate in employer-sponsor group health insurance plans. There are no current Federal requirements that employer-sponsored health plans provide specific benefits to plan participants. For those employer group plans who are also covered by Medicare, employer plans are generally coordinated to supplement Medicare benefits or provide benefits that Medicare does not cover.

The proposed Medicare catastrophic legislation would result in duplicative coverage for many of those individuals receiving both Medicare and employer-sponsored health benefits.

House bill

No provision.

Senate amendment

(a) In General.—Provides that for the 1-year period beginning on the date of enactment of this act, if an employer provides health benefits to an employee or retired former employee (including a Federal employee or retired Federal employee) that are duplicative of new or improved health care benefits provided under this act or the amendments made by this act, the employer shall: (1) provide additional benefits to the employee or retired former employee that are at least equal in value to the duplicative benefits; or (2) refund to the employee or retired former employee an amount equal to the actuarial present value of the duplicative benefits.

(b) Regulations.—Requires the Secretary of Labor to issue such regulations as are necessary to carry out this provision.

Effective date.—Effective (1) during the 1-year period beginning on the date of enactment of this act; or (2) in the case of an employer who is providing duplicative health care benefits to employees or retired former employees under a collective bargaining agreement that is in effect on the date of enactment, until the expiration of the agreement.

Conference agreement

(a) *In General.*—The conference agreement includes the Senate amendment with the following amendments. Employers who, on enactment, provide health care benefits to employees or retired former employees that duplicate Part A benefits or Part B benefits (excluding covered outpatient drugs) as amended by this Act must provide to the employees or retired former employees an amount of additional benefits (which could include payment of the part B premium) or refunds, or both, that total at least the actuarial value of the duplicative Part A benefits or Part B benefits (excluding covered outpatient drugs). Duplicative benefits are determined net of any premiums paid employees or retired former employees that are attributable to the duplicative benefits.

(b) *Employers Covered.*—Employers (including public employers other than the Federal government) affected by this provision include those who provide duplicative Part A benefits whose actuarial value is at least 50 percent of the actuarial value (discounted to the value as of the date of enactment) of the average Part A benefits provided under this bill.

Also, employers (including public employers other than the Federal government) affected by this provision include those who provide duplicative Part B benefits whose actuarial value is at least 50 percent of the actuarial value (discounted to the value as of the date of the enactment) of the average Part B benefits that will be provided under this bill.

The conferees intend that employers contributing to a multiemployer plan would be required to continue their contributions under their collective bargaining agreements.

Employers may elect to compute the actuarial value of duplicative Part A or Part B benefits on the basis of: (1) national average actuarial values, or (2) the actuarial value (net of employee premiums) with respect to that employer. The Secretary of Health and Human Services must calculate and publish for four years begin-

ning with 1989 for duplicative Part A benefits, and 1990 for duplicative Part B benefits, the national average actuarial value of the duplicative benefits for 1988 and the year involved, and the employer guidelines for computing the actuarial value of duplicative benefits for such years.

(c) *Effective Period.*—The conference agreement includes the Senate amendment, with a modification that the maintenance of effort requirements with respect to duplicative Part A benefits are effective during 1989, and the maintenance of effort requirements with respect to duplicative Part B benefits are effective during 1990. However, where there is a collective bargaining agreement in effect of the date of enactment, the maintenance of effort requirements are in effect until the later of 1989 for Part A benefits and 1990 for Part B benefits or the expiration of the agreement, determined without regard to any extensions after enactment.

(d) *Effective date.*—The conference agreement is effective on enactment.

33. Medicaid Buy-In of Premiums and Cost-Sharing for Indigent Medicare Beneficiaries (Section 301 of House bill; Sections 14 and 14B of Senate amendment)

Present law

Most States have entered into a "buy-in" agreement under which they pay the Medicare Part B premiums on behalf of their Medicaid beneficiaries who are also eligible for Medicare.

The Omnibus Budget Reconciliation Act of 1986 (OBRA 86) permits States to cover Medicare premiums, deductibles, and coinsurance for aged and disabled persons with incomes up to a State-established level, which may be up to 100 percent of the Federal poverty line. A State choosing this option is required to use the resource standards of the Supplemental Security Income (SSI) program; except that if it has a medically needy program using higher standards it may use those standards. States electing this option are required to offer Medicaid coverage "to some or all" newly pregnant women and children below the Federal poverty line.

House bill

(a) In General.—Makes mandatory the current option for States to pay Medicare premiums, deductibles and coinsurance for all elderly and disabled persons with incomes at or below 100 percent of the Federal poverty level, except that resources would be set at or below twice the SSI standard. The requirement that States cover some newly eligible pregnant women and children is retained. A State which is providing medical assistance under a section 1115(a) waiver instead of under Medicaid is required to meet the mandatory coverage requirement. The coverage requirement is optional with the commonwealths and territories, and they may use an income level below 100 percent of the Federal poverty line.

(b) Drug Provisions.—(See Item 10, "Coverage of Catastrophic Prescription Drugs Under Medicare").

(1) Requires State Medicaid programs to cover incurred drug charges below the Medicare deductible for Medicare beneficiaries with incomes below poverty. Alternatively, a State may

provide the same drug coverage (up to the deductible) as is offered to categorically needy Medicaid beneficiaries in the State.

(2) No provision.

Effective date.—(a) Applies to calendar quarters beginning on or after July 1, 1988 (without regard to whether or not final regulations have been promulgated) with respect to medical assistance for monthly Medicare premiums beginning July 1, 1988, and items and services furnished on or after that date. Delay is permitted where State legislation is required.

(b) Applies for calendar quarters beginning on or after January 1, 1989 (without regard to whether or not final regulations have been promulgated) with respect to medical assistance for monthly Part B premiums beginning January 1, 1989, and covered outpatient drugs dispensed on or after that date; delay is permitted where State legislation required.

Senate amendment

(a) In General.—Requires the Secretary, before the beginning of each fiscal year, to estimate the amount that would have been expended from State funds that fiscal year for Medicaid in the absence of the catastrophic protection offered under the bill and to notify each State of the amount. Each State is required to use such estimated savings for one or more of the following:

(1) Paying for Medicare cost-sharing charges (other than those for covered outpatient drugs) for persons below the poverty line, pursuant to the provisions of OBRA 86 (except that requirements pertaining to additional coverage of pregnant women and children would not apply);

(2) Increasing the monthly maintenance needs allowance for community spouses of institutionalized individuals; or

(3) Increasing opportunities for elderly persons to participate in adult day health and other community-based services, if the State both: (A) has elected to provide coverage for Medicare cost-sharing charges for persons with incomes up to 100 percent of poverty, and (B) provides a minimum monthly income allowance for community spouses up to $500 per month.

The amounts expended by the State under this provision are in addition to any amounts that would have otherwise been expended for such purposes.

(b) Drug Provisions.—(See Item 10, "Coverage Catastrophic Drugs Under Medicare".)

(1) Similar provision.

(2) Permits States to cover Medicare prescription drug cost-sharing charges for persons whose income is between 100 and 200 percent of poverty. For persons with incomes up to 150 percent of poverty, the deductible can be up to $150 and the cost sharing amount up to 10 percent of any coinsurance amounts otherwise paid by the State. For persons with incomes above 150 percent of poverty, the deductible can be up to $300 and the coinsurance up to 15 percent.

Effective date.—(a) Applies for 12 successive calendar quarters beginning January 1, 1988, except delay is permitted where State

legislation is required. In case of delay, the provision is also effective for 12 successive calendar quarters.

(b) Applies to Medicaid payments for calendar quarters beginning on or after January 1, 1990 (without regard to whether final regulations have been issued) with respect to monthly Medicare premiums and items and services furnished on and after January 1, 1990.

Conference agreement

(a) *In General.*—The conference agreement follows the House provision with modifications. Except with respect to certain "209(b)" States, the buy-in requirement would be phased in as follows: effective January 1, 1989, States would have to buy-in the elderly and disabled with incomes at or below 85 percent of the Federal poverty income guidelines ($5,770 per year in 1988 for an individual); effective January 1, 1990, at or below 90 percent; effective January 1, 1991, at or below 95 percent; and effective January 1, 1992, at or below 100 percent. With respect to those five "209(b)" States that, as of January, 1987, used more restrictive income eligibility standards with respect to the elderly than those applicable under SSI, the buy-in requirement would be phased in as follows: effective January 1, 1989, these States would be required to offer buy-in coverage to individuals with income at or below 80 percent of the Federal poverty income guidelines; effective January 1, 1990, at or below 85 percent; effective January 1, 1991, at or below 90 percent; effective January 1, 1992, at or below 95 percent; and effective January 1, 1993, at or below 100 percent. The conferees understand that five "209(b)" States qualify for this extended phase-in schedule: Hawaii, Illinois, North Carolina, Ohio, and Utah, (See CRS Report 87-986 EPW, Appendix B-2).

The conferees note that the current option to offer buy-in coverage would remain in effect during the phase-in period. Thus, States which currently offer buy-in coverage to the elderly or disabled with income at or below 100 percent of the Federal poverty guidelines but above the mandatory phase-in schedule (i.e., Florida, New Jersey, Rhode Island, and the District of Columbia) could continue to receive Federal matching payments for such coverage. Similarly, States that, over the next three years, wish to offer buy-in coverage to individuals with incomes above the mandatory phase-in schedule (but no higher than 100 percent of poverty) may do so.

The conference agreement clarifies the standard in the House bill that States cover "some or all" pregnant women and infants. Under the agreement, States are required, effective July 1, 1989, to extend coverage to pregnant women and infants up to age 1 with incomes at or below 75 percent of the Federal poverty income guidelines ($9,690 in 1988 for a family of 3); effective July 1, 1990, the requirement applies to all pregnant women and infants with incomes at or below 100 percent of poverty. In the case of pregnant women, coverage would be limited to pregnancy-related services; in the case of infants, coverage would extend to all Medicaid benefits offered be the State to cash assistance recipients. Those States that, as of enactment, offered overage to pregnant women and infants with incomes at or below 100 percent of the poverty level (or some lower income threshold higher than 75 percent) would be required

to continue this coverage. This maintennance of effort requirement would also apply to States that, as of enactment, had enacted authorizing or appropriations legislation to establish such coverage but had not yet actually implemented the coverage. As under current law, States that elected to offer Medicaid coverage to pregnant women and infants above the mandatory income thresholds up to 185 percent of the Federal poverty level would not be permitted to reduce their cash assistance payment levels to families with dependent children below the levels in effect as of July 1, 1987. Similarly, to assure that the resources for mandatory coverage of pregnant women and infants up to 100 percent of poverty are not diverted from the Aid to Families with Dependent Children (AFDC) program, all States are prohibited from reducing their cash assistance payment levels to families with dependent children below the levels in effect on May 1, 1988.

The conference agreement also provides that states which impose durational limits on Medicaid payments for inpatient hospital services (e.g., 12 days per year, 14 days per admission, 30 days per spell of illness, 35 days for a particular diagnosis under a prospective payment system) must establish exceptions to any such limit for medically necessary inpatient services received by an infant (up to age 1) in a hospital designated as a disproportionate share hospital under the State's Medicaid plan. Thus, so long as the infant remains Medicaid-eligible and is receiving medically necessary inpatient services in a disproportionate share hospital, the State would be obligated to reimburse the hospital for such services without regard to any durational limit that might otherwise apply. The agreement further provides that, if a State pays for inpatient hospital services on a prospective basis (per diem, per case, or otherwise), the State must provide for an outlier adjustment for disproportionate share hospitals for medically necessary inpatient services delivered on or after July 1, 1989, involving exceptionally high cost or exceptionally long lengths of stay for infants up to age 1. States would have the discretion to define length of stay and cost outliers, and to determine the amount of adjustment to be paid for outlier cases; however, reimbursement to disproportionate share hospitals for these exceptionally high costs or exceptionally long length of stay infants would have to be reasonable and adequate. States are required to submit a plan amendment setting forth their outlier policy by April 1, 1989; the Secretary is required to review and approve or disapprove such amendment within 90 days. If the Secretary disapproves the amendment, the State is required to submit immediately a complying amendment. This requirement applies to all States, including those with "prudent buyer" contracting waivers under section 1915(b)(4) of the Social Security Act.

(b) *Drug Provisions.*—

(1) The conference agreement follows the House provision with a modification providing for a phase-in schedule corresponding to the schedule applicable to the general buy-in requirement described in (a), above. Thus, as of January 1, 1991, when the Medicare prescription drug benefit takes effect, most States will be required to buy-in the elderly and disabled with incomes at or below 95 percent of the Federal poverty level; in the five "209(b)" States for which a longer phase-in schedule is

specified, the 90 percent threshold will apply. The managers note that, if the State elects the option of providing its Medicaid drug benefits in order to satisfy the Medicare prescription drug deductible, the "charges for covered outpatient drugs" are the billed charges for the drugs that Medicaid covers, even though the beneficiary has not actually incurred the charge or paid the difference between the State's payment (plus any coinsurance requirement) and the pharmacist's charge.

(2) The conference agreement does not include the Senate provision.

Effective date.—Applies to calendar quarters beginning on or after January 1, 1989 (without regard to whether or not final regulations have been promulgated) with respect to medical assistance for monthly Medicare premiums beginning on that date, and items and services furnished on or after that date. Delay is permitted where specified State legislation is required. The disproportionate share hospital payment provision is effective on enactment.

34. Determination of Medicaid Drug Savings; State Plan Requirement (Section 14A of Senate amendment)

Present law

No provision.

House bill

No provision.

Senate amendment

Requires the Secretary before the beginning of each fiscal year (or portion thereof) to estimate and determine the amount that would have been spent in each State that fiscal year under Medicaid in the absence of the new outpatient drug coverage and intravenous drug coverage provisions, and to notify the State of the amount.

Requires each State plan to use any such savings for covering Medicare drug cost sharing charges for persons below the poverty line.

Effective date.—Applies with respect to any calendar quarter beginning on or after January 1, 1990.

Conference agreement

The conference agreement does not include the Senate provision.

35. Protection of Income and Resources of Couple for Maintenance of Community Spouse (Section 302 of House bill; Section 14C of Senate amendment)

Present law

(a) In General.—Eligibility of the aged and disabled for Medicaid is linked to actual or potential receipt of cash assistance under SSI. The SSI program employs certain criteria for the treatment of income and resources which are also used in States which cover all SSI recipients. ("209(b)" States which do not cover all SSI recipi-

ents, may employ more restrictive criteria, provided they are no more restrictive than those in effect in January 1972).

An institutionalized individual with a spouse in the community is permitted to keep an amount for the maintenance needs of his spouse; however this amount is set at welfare levels. As a result of Medicaid rules, both for determining eligibility and in the treatment of income after eligibility has been established, the spouse in the community may be left with income below the poverty level; this circumstance is referred to as spousal impoverishment.

(b) Rules for Treatment of Income.—Under SSI rules, if both spouses live together, their incomes and resources are considered available to each other whether or not they actually contributed to each other. Spouses are no longer considered to be living together if one is institutionalized for longer than one month in a facility certified to receive Medicaid payments. Only the income of the institutionalized spouse is considered for purposes of determining eligibility. In most states the "name on the instrument" rule applies in attributing income; i.e., income is considered to belong to the spouse whose name is on the check or other instrument conveying the funds. (In the case of Social Security checks, the amount attributable to each spouse is the individual's share of the couple's benefit.) A Federal Appeals Court has ruled that in California and Washington, community property principles, and not the "name on the instrument" rule, apply.

(c) Rules for Treatment of Resources.—Resources must be considered mutually available for 6 months following institutionalization if both spouses are SSI eligible and for 1 month if only one spouse is SSI eligible. Countable resources above specified amounts (including a minimum of $1,900 in liquid resources for an individual and $2,850 for a couple) must be applied to the costs of care. Excluded from the calculation is the couple's home and $2,000 in equity value of household goods or personal effects. If resources are held solely by the institutionalized spouse, they are attributed to him for eligibility purposes. If they are held jointly by the institutionalized spouse and the noninstitutionalized spouse, they are considered to belong entirely to the institutionalized spouse. If they are held solely by the spouse remaining in the community, none is considered available to the institutionalized spouse.

(d) Protecting Income for Community Spouse.—After an institutionalized individual has established eligibility, his income, after deduction of specified amounts known as "disregards," is applied to the cost of care. The disregards are applied to the resident's income in the following order:

(1) A monthly personal needs allowance (which must be at least $25) ($30 as of July 1, 1988);

(2) A monthly maintenance needs allowance for an individual with a spouse at home which may not exceed: (A) the SSI standard for an individual residing in his own home, (B) the highest income standard for State optional supplementary payments, or (C) the medically needy standard for one person. (A State not covering all SSI recipients cannot use a level higher than the more restrictive income standard or the medically needy standard);

(3) An additional allowance for an individual with a family at home.

(4) Amounts for medical expenses not covered by a third party, subject to reasonable limits. (The Health Care Financing Administration (HCFA) has issued a regulation that, effective April 8, 1988, makes this disregard optional with the State.

(e) Notice and Hearing.—No provision.

(f) Court Ordered Support.—In certain instances State or local courts have issued orders against institutionalized spouses requiring them to make monthly payments to the community spouse. However, notwithstanding such an order, the Health Care Financing Administration (HCFA) has determined that the income of the institutionalized spouse is available to him for purposes of determining his contribution to the cost of care.

(g) Transfer of Assets.—The fair market value of any resources (not including the individual's home) disposed of within the preceding 24 months must be taken into account in determining SSI eligibility (to which Medicaid eligibility is linked). States are permitted, but not required, to impose such a restriction for Medicaid provided it is not more restrictive than that for SSI, with one exception. In cases where the uncompensated value of disposed resources exceeds $12,000, the State may provide for a period of ineligibility exceeding 24 months, provided the period bears a reasonable relationship to the uncompensated value. States may waive the delay in Medicaid eligibility in cases of undue hardship.

States are also allowed to deny Medicaid eligibility for 24 months to institutionalized individuals who, within 24 months prior to application for Medicaid, disposed of their homes for less than fair market value even though such disposal would not make them ineligible for the SSI program. The provision does not apply if the individual intended to dispose of the home at fair market value or if title was transferred to a spouse or minor or handicapped child.

(h) Conforming Amendment.—Some States covering the aged and disabled medically needy use less restrictive income or resource methodologies than are applied under the SSI program. HCFA has interpreted current law to require that States use SSI income and resource methodologies. A moratorium on this interpretation enacted in section 2373(c) of P.L. 98-369, and clarified by section 9 of P.L. 100-93, is currently in effect.

(i) Study of Means of Recovering Costs of Nursing Facility Services From Estates of Beneficiaries.—Under certain circumstances, States may recover amounts paid on behalf of deceased beneficiaries who were nursing home residents or who were 65 or over when Medicaid payments were made.

House bill

(a) In General.—

(1) Adds a new Section 1921 to the Social Security Act entitled "Treatment of Income and Resources For Certain Institutionalized Spouses". The provisions of this section supersede other provisions of title XIX, to the extent they are inconsistent, for purposes of determining eligibility of an institutionalized spouse. Comparable treatment is not required for other groups of eligibles.

(2) Specifies that, except as specifically provided, the section does not apply to the determination of what constitutes income or resources or the methodology and standards for determining and evaluating them.

(3) Permits an institutionalized spouse to elect to be governed instead by the rules in effect in March 1987 in his State, except that the institutionalized spouse may not opt out of the new rules regarding treatment of resources at the time of initial eligibility determination.

(4) Specifies that the new section applies to a State operating under a section 1115 waiver but not to the commonwealths and territories.

(b) Rules for Treatment of Income.—

(1) Specifies that in any month in which a spouse is institutionalized, no income of the community spouse is considered available to the institutionalized spouse.

(2) Specifies that, regardless of State laws relating to community property or division of marital property, the following income attribution rules apply for non-trust property unless otherwise specifically provided on the instrument. Income paid solely to one spouse or another is considered to belong to that respective spouse. If the income is paid in both names, half is considered available to each spouse. If the income is paid in the name of either or both spouses and another person, an equal share of the income is considered available to each individual. The same principles apply for trust property unless the trust specifically provides otherwise. For non-trust property with no instrument, half of the income is considered available to each spouse.

(3) An institutionalized spouse can rebut the non-trust property attribution rules by establishing that ownership interests are otherwise.

(4) No provision.

(c) Rules for Treatment of Resources.—

(1) Provides for the computation, as of the beginning of a continuous period of institutionalization, of the spousal share which is equal to one-half the value of all the resources held by the institutionalized spouse, the community spouse, or both. The couple's house and all household goods and personal effects are to be excluded from the calculation.

(2) Provides that the determination of countable resources is to be made regardless of State laws relating to community property or division of marital property, at the time of application for benefits. All resources held by either spouse are considered available to the institutionalized spouse except that the resources held in the name of the community spouse are not considered available unless they exceed a community spouse resource allowance (as of the application date) or if greater, the amount retained under court order.

(3) No provision.

(4) Provides that after an institutionalized spouse has established eligibility, no resources of the community spouse shall be considered available to the institutionalized spouse.

(5) Specifies that if the spousal share is less than $12,000 (indexed to the CPI beginning in 1989), the institutionalized spouse is allowed to transfer an amount sufficient to enable the community spouse to hold $12,000 in his or her own name. If the spousal share is greater than $48,000 (indexed by the CPI beginning for 1989), the amounts in excess of $48,000 would be attributed to the institutionalized spouse.

(d) Protecting Income for Community Spouse.—Specifies that the following disregards are to be applied to the institutionalized individual's income in the following order:

(1) A monthly personal needs allowance as specified under current law;

(2) A minimum monthly maintenance needs allowance for the community spouse. The allowance is the amount needed to bring the community spouse's monthly income up to a minimum level (not to exceed $1,500, indexed to the CPI beginning for 1989) which is the sum of:

(A) 150 percent of the Federal poverty guidelines for a family of two;

(B) an excess shelter allowance (the amount by which mortgage expenses or rent, plus utility costs, exceed 30 percent of Item A); and

(C) one-half of the amount by which the income of the institutionalized spouse exceeds the sum of items A and B;

(3) A family allowance for each family member (minor or dependent child, dependent parent or dependent sibling residing with the community spouse) equal to at least one-third of the amount by which 150 percent of the Federal poverty line for a family of two exceeds the family income of that family member.

(4) Amounts for incurred medical expenses not subject to payments by a legally liable third party.

(e) Notice and Hearing.—

(1) Requires States to notify the institutionalized spouse of the community spouse monthly income allowance, the family allowance, the method for computing the amount of the community spouse resource allowance, and of the spouse's right to a fair hearing with respect to the determination of the community spouse monthly income allowance.

(2) Specifies that if the institutionalized spouse establishes that the minimum monthly maintenance needs allowance is inadequate to support the community spouse without financial duress, the amount is to be increased.

(f) Court Ordered Support.—

(1) Provides that if a court has entered an order against an institutionalized spouse for monthly income support for the community spouse, the community spouse monthly maintenance needs allowance must be at least as great as the court ordered amount.

(2) Provides that if a court has entered a support order against an institutionalized spouse requiring the spouse to transfer countable resources to the community spouse, such transfer will not be considered in violation of transfer of assets prohibitions.

(3) Provides that if a court has entered an order against an institutionalized spouse requiring the spouse to transfer resources, the community spouse resource allowance is the amount transferred up to the ceiling ($48,000 in 1988, indexed to the CPI in future years).

(g) Transfer of Assets.—

(1) Requires States to determine, at the time of application, whether an institutionalized individual has disposed, within the preceding 24 months, of resources for less than fair market value. If such a transfer has occurred, a period of ineligibility is established beginning with the month in which the resources were transferred. The number of months in such period equals the total uncompensated value at the time of transfer divided by the average cost of nursing home care to a private patient in the State or community.

(2) Specifies that the transfer prohibition does not apply if:

(A) the transfer was that of the applicant's home to his or her spouse, child under 21 or blind or disabled adult child;

(B) resources were transferred to the community spouse;

(C) a satisfactory showing is made that the individual intended to dispose of resources at fair market value or for other valuable consideration; or

(D) the State determines that denial of eligibility would work an undue hardship. States can only employ transfer of resources restrictions in accordance with these provisions.

(h) Conforming Amendment.—Provides that a State's methodology for determining eligibility for the medically needy may not be more restrictive than that under the appropriate cash assistance program. The methodology is considered to be no more restrictive if, in using the methodology, additional individuals may be eligible and no otherwise eligible individuals are made ineligible.

(i) Study of Means of Recovering Costs of Nursing Facility Services From Estates of Beneficiaries.—No provision.

Effective Date.—Applies to payments made for calendar quarters beginning on or after January 1, 1988, without regard to whether final regulations have been issued. Delay is permitted where State legislation required. The conforming amendment item (h) applies to medical assistance furnished on or after October 1, 1982.

Senate amendment

(a) In General.—Identical provision, except excludes item 3.

(b) Rules for Treatment of Income.—

(1) Identical provision.

(2) Similar provision except: (A) applies only to post-eligibility treatment of income; and (B) in the case of both trust and non-trust property where the income is paid in the name of either or both spouses and another person, the income is considered available to each spouse in proportion to the spouse's interest (or if payment is made with respect to both spouses and no such interest is specified, one-half of the joint interest shall be considered available to each spouse).

(3) Identical provision.

(4) Specifies that in the case of community property States that do not provide coverage for the medically needy, the amount of income considered available to each spouse, at the time of application for benefits, is equal to half of the combined income of the institutionalized and community spouse.

(c) Rules for Treatment of Resources.—

(1) Similar provision. Also excludes resources that are necessary to produce income that is available to the community spouse or the family allowance up to the limits established by this section (see (d) below).

Requires the State to provide an assessment and documentation of total joint resources at the request of either spouse, at the beginning of a continuous period of institutionalization. The assessment shall occur promptly on receipt of relevant documentation. A copy is to be provided to each spouse. A State may charge a reasonable fee for an assessment if it is not part of an application for Medicaid.

(2) Similar provision.

(3) Specifies that the institutionalized spouse is not considered ineligible by resources determined to be available where: (A) the institutionalized spouse has assigned to the State any rights to support from the community spouse; (B) the institutionalized spouse lacks the ability to excute an assignment due to physical or mental impairment but the State has a right to bring a support proceeding against a community spouse without such assignment; or (C) the State determines denial of eligibility could work an undue hardship.

(4) Identical provision.

(5) Similar provision, except: (A) a State, by law, practice, policy, or State plan (whether approved or not), may establish a higher amount than $12,000; and (B) specifies that a higher amount may be established by fair hearing or court order. Specifies that a transfer of resources to a community spouse must be made within 1 year after the date of the initial eligibility determination or such time as is necessary to obtain a court order (whichever is longer.)

(d) Protecting Income for Community Spouse.—Similar provision, except:

(1) The definition of personal needs allowance is tied to that specified under the bill.

(2) The minimum allowance for the community spouse may be increased by State law, policy, or State plan (whether approved or not):

(A) The minimum maintenance needs allowance is 122 percent of the poverty line;

(B) Similar provision.

(C) No provision.

(3) Similar provision, except family allowance linked to 122 percent of Federal poverty line.

(4) Similar provision.

(e) Notice and Hearing.—

(1) Similar provision, execpt requires specific notice to both spouses at the time of eligibility determination or to either spouse upon request. Also requires notification of the spouse's

right to a fair hearing respecting ownership or availability of income or resources, and respecting the community spouse monthly income or resource allowance.

(2) Specifies that if either spouse establishes that either the minimum monthly maintenance needs allowance or the community spouse resource allowance (in the relation to the amount of income generated by such allowance) is not adequate to support the community spouse without financial duress, the amount of either allowance is to be increased.

(f) Court Ordered Support.—

(1) Similar provision.

(2) Similar provision.

(3) Similar provision, except ceiling does not apply.

(g) Transfer of Assets.—Similar provision except that the State review covers the disposal of assets within the 26 months prior to application.

(2) Similar provision, except:

(A) specifies transfer prohibition does not apply (i) in the case of a sibling who has an equity interest in the home and was residing in the home for at least a year prior to the individual's admission to a nursing home, or

(ii) in the case of a son or daughter who was residing in the home for at least two years prior to the admission and was providing care which permitted the individual to reside at home.

(B) also permits transfer to the individual's child who is permanently or totally disabled.

(C) also permits a showing that resources were transferred exclusively for a purpose other than to qualify for medical assistance.

(D) Identical provisions.

(h) Conforming Amendment.—Identical provision.

(i) Study of Means of Recovering Costs of Nursing Facility Services From Estates of Beneficiaries.—Requires the Secretary to study the means for recovering the amounts from the estates of deceased beneficiaries (or the estates of spouses of deceased beneficiaries) to pay for SNF or ICF services furnished them under Medicaid. The Secretary is required to report to Congress, not later than December 31, 1988, on such means, and to include appropriate recommendations for changes.

Effective date.—Applies to payments made for calendar quarters beginning on or after January 1, 1988, without regard to whether final regulations have been issued. Delay is permitted where State legislation required. Provisions relating to treatment of resources, apply only to institutionalized individuals who begin continuous periods of institutionalization on or after January 1, 1988. Transfer of assets provisions, item (g) apply only to transfer of resources made on or after January 1, 1988.

Conference agreement.

(a) *In General.*—The conference agreement follows the Senate amendment.

(b) *Rules for Treatment of Income.*—The conference agreement follows the Senate amendment with a modification deleting the provision relating to community property States that do not offer

coverage to the medically needy (item (4) of the Senate amendment).

(c) *Rules for Treatment of Resources.*—The conference agreement follows the Senate amendment with the following modifications. If the spousal share the couple's total resources is greater than $60,000 (indexed by CPI beginning in 1990), amounts in excess of $60,000 would be attributed to the institutionalized spouse. A level higher than $60,000 could be established by fair hearing or court order. The State, by amending its State plan, could raise the $12,000 minimum resource allowance for the community spouse to any level up to the $60,000 (subject to indexing) statutory maximum.

The agreement does not exclude from countable resources those assets necessary to produce income available to the community spouse or the family allowance. Instead, the agreement provides that either the institutionalized or the community spouse may request a fair hearing as to whether the community spouse resource allowance is adequate to generate sufficient income to raise the community spouse's income to the minimum monthly maintenance needs allowance. The State must grant such a hearing within 30 days of request. If the State, after such a hearing, determines that the community spouse resource allowance is inadequate, the State must allow the community spouse to retain an adequate amount of resources to provide the minimum monthly maintenance needs allowance (taking into account any other income attributable to the community spouse), notwithstanding the amount of the State-established resource allowance. If either spousel requests an assessment or resources at the time of institutionalization, the State must, in providing the assessment give notice to the requesting spouse of the right to a fair hearing with respect to the adequacy of the community spouse's resource allowance. The agreement also requires that nursing facilities inform newly-admitted residents of their right to request an assessment from the State agency.

The conference agreement specifies that a transfer of resources to a community spouse must be made as soon as practicable after the date of initial eligibility determination, with allowance for the time necessary to obtain a court order, where necessary. In determining what constitutes a "transfer" for this purpose, the conferees intend that State law govern. In addition, the agreement provides that the State of Missouri must not count as a resource the home (of any value) of an aged, blind, or disabled individual who applies for Medicaid on or after October 1, 1989. This requirement would apply only to the home; the State could, but would not be requird to, exclude the land that appertains to the house, as would be the case under SSI.

(d) *Protecting Income for Community Spouse.*—The conference agreement follows the Senate amendment with the following modifications. As under current law, the proposal needs allowance is $30, whether the resident is eligible for Medicaid on a categorically needy, optional categorically needy, or medically needy basis. The minimum monthly maintenance needs allowance is effective September 30, 1989, set at 122 percent of the monthly Federal poverty income guidelines for a 2-person household (which is 1988 would be $786). Effective July 1, 1991, the minimum allowance would be

raised to 133 percent; effective July 1, 1992, to 150 percent. This schedule of percentage would also apply to the calculation of the family allowance. The community spouse monthly maintenance needs allowance may not exceed $1500, except where a higher level is determined to be necessary through a fair hearing or by a court order.

With respect to the deduction for incurred medical expenses, the conference agreement requires that, with respect to any Medicaid-eligible individual in an institution (regardless of whether the individual has a spouse in the community), States must take into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including Medicare and other health insurance premiums, deductibles, or coinsurance, and, subject to reasonable limits a State may establish, necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan. The conferees note that, until recently, HCFA regulations required that Medicaid-eligible nursing home residents be allowed to deduct uncovered medical costs from their income before contributing toward the cost of nursing home care. However, a recent HCFA regulation, 53 *Fed. Reg.* 3586 (Feb. 8, 1988), altered this rule to allow States to limit this deduction substantially, or to eliminate it altogether. The conference agreement is intended to reinstate the previous rule, retroactive to the effective date of the recent change (April 8, 1988). As under the previous regulation, States will have the ability to place "reasonable limits" on a resident's expenditures for medical or remedial care. The conferees wish to emphasize that these limits must ensure that nursing home residents are able to use their own funds to purchase necessary medical or remedial care not covered by the State Medicaid program, while minimizing opportunities for providers to take financial advantage of either the program or the residents. For example, it would be reasonable for a State to provide that only uncovered services prescribed by a physician may be deducted. It would also be reasonable for States to impose specific dollar limits for specific services or items, provided that these limits reflect annual increases in the cost of medical care services and supplies. However, it would not be reasonable for States to set an overall dollar limit, such as $50 per month, for all noncovered services. Similarly, it would not be reasonable for States to impose a limit on the number of medically necessary services or items that an individual could deduct in any month. In providing these examples of "reasonable limits" for deductions of uncovered medical expenses incurred by nursing home residents, the conferees do not intend any approval of camparable limitations in the "spenddown" process for medically needy programs.

(e) *Notice and Hearing.*—The conference agreement follows the Senate amendment with the following modification. If either the community or institutionalized spouses establishes in a fair hearing that, due to exceptional circumstances resulting in significant financial duress, the community spouse needs income above the minimum monthly maintenance needs allowance, the State is required to increase the allowance to provide this amount, notwithstanding the $1500 statutory ceiling. Exceptional circumstances resulting in significant financial duress would include, but not be limited to,

the financial burden of caring for a disabled child, sibling, or other immediate relative. If either spouse establishes in a fair hearing that the community spouse resource allowance (in relation to the income generated by such allowance) is inadequate to raise the income of the community spouse to the level of the minimum monthly maintenance needs allowance (taking into account any other income attributed to the community spouse), the State must provide for a resource allowance adequate in amount to generate that level of income for the community spouse.

(f) *Court-ordered Support.*—The conferences agreement follows the Senate amendment.

(g) *Transfer of Assets.*—The conference agreement follows the Senate amendment, with a modification. The transfer of assets prohibitions apply only with respect to individuals institutionalized in a medical institution or nursing facility. The term "medical institution" has the same meaning as under current regulations, 42 C.F.R. section 435.1009; the term "nursing facility" includes a skilled nursing facility or intermediate care facility (other than an ICF for the mentally retarded), until October 1, 1990, when these categories will be replaced by "nursing facility." States are required to determine whether these individuals made any prohibited resource transfers within 30 months prior to application for benefits. This requirement is effective with respect to applications for Medicaid eligibility occurring on or after July 1, 1988 and applies only with respect to resources transferred on or after July 1, 1988. Thus, in those States which do not have transfer or assets prohibitions in place prior to July 1, 1988, the State can look back only to transfers occurring on or after July 1, 1988. In those States that, prior to July 1, 1988, have exercised their option to penalize transfers of assets for less than fair market value, the State may continue to apply its pre-July 1 transfer policies and penalties with respect to resources transferred prior to July 1, 1988, even in cases where application for Medicaid benefits is made after on or after that date. However, with respect to resource transfers occurring on or after July 1, 1988, the rules set forth in the conference agreement regarding computation of the period of ineligibility and exceptions to the transfer prohibition will apply in all States, including the "209(b)" States which have elected the option to use more restrictive eligibility standards with respect to their aged, blind, and disabled beneficiaries than apply under SSI.

The conference agreement also repeals the provision in present SSI law which requires that the uncompensated value of resources transferred at less than fair market value within the preceding 24 months be counted toward the SSI resource limit. However, under the conference agreement, a transfer of resources at less than fair value by an SSI applicant or recipient will be considered in determining an individual's eligibility for Medicaid if and when the individual enters a medical institution or nursing facility. Such transfers may include, for example, the SSI applicant's or recipient's home even though at the time of the transfer the home was not a countable SSI resource. Therefore, the conference agreement will require that the Secretary inform SSI applicants in writing, at the time of application, and SSI recipients, at the time of redetermination of eligibility, of the provisions of Medicaid law with respect to

transfer of assets. The Secretary will be required to request from the individual information about transfers and, at the time of such request, to inform the individual that such information may be shared with the State Medicaid agency. The Secretary will also be required to make this information available to a State Medicaid agency, upon request; the State may, at its option, use this information to determine whether and to what extent there will be a period of ineligibility for Medicaid because an individual transferred resources at less than fair market value.

(h) *Conforming Amendment.*—The conference agreement follows the House bill, which applies to States which cover the medically needy, with a modification extending its application to States which offer coverage to optional categorically needy individuals and to "209(b)" States as well. Under the moratorium imposed by section 2373(c) of P.L. 98–369, as clarified by section 9 of P.L. 100–93, States have flexibility to establish income and resource methodologies under medically needy programs, optional categorically needy programs, and under the "209(b)" option that are less restrictive, i.e. more generous, than those applied in the corresponding cash assistance programs. The conference agreement codifies this flexibility, retroactive to October 1, 1982.

(i) *Study of Means of Recovering Costs of Nursing Facility Services from Estates of Beneficiaries.*—The conference agreement includes a technical amendment reflecting the Senate amendment, the text of which had been agreed to in, but was inadvertently ommitted from, the Omnibus Budget Reconciliation Act of 1987, P.L. 100–203. The conference agreement includes additional OBRA '87 technical corrections and other miscellaneous provisions.

With respect to section 4112 of OBRA '87, relating to payment adjustments for disproportionate share hospitals, the conference agreement makes a number of technical corrections regarding the 3-year phase-in and other matters. It clarifies that the special rule in subsection 4112(e) applies only to New York, and adds a special rule providing that, for a 3-year period, Texas may use its own definition of disproportionate share hospital and its own payment adjustment rules so long as the aggregate amount payment adjustments to disproportionate share hospitals is not less than the amount that would be required by section 4112. During this 3-year period, in meeting the requirement that at least two obstetricians with staff privileges agree to provide obstetric services to Medicaid patients, a hospital in an urban area in Texas seeking disproportionate share status could substitute family practitioners, internists, or any other qualified physician with staff privileges.

The conference agreement clarifies that Federal Medicaid matching funds are available for the cost of health services, covered under a State's Medicaid plan, that are furnished to a handicapped child or a handicapped infant or toddler, even though such services are included in the child's individualized education program or individualized family service plan. Under the Education for All Handicapped Childeren Act of 1975, P.L. 94–142, children with handicaps are entitled to a free and appropriate public education in conformity with an individualized education program (IEP) which describes the educational and "related services" necessary to

meet the child's unique needs. While the State education agencies are financially responsible for educational services, in the case of Medicaid-eligible handicapped child, State Medicaid agencies remain responsible for the "related services" indentified in the child's IEP if they are covered under the State's Medicaid plan, such as speech pathology and audiology, psychological services, physical and occupational therapy, and medical counseling and services for diagnostic and evaluation purposes.

The conference agreement defines an institution for mental diseases (IMD) as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. This would clarify that Federal Medicaid matching funds would be available for services such as personal care and case management that are furnished through or by group homes or other small facilities serving the mentally ill, if those services are covered by the State under its Medicaid plan. The 16-bed limitation parallels current rules under the SSI program.

The conferees wish to clarify the requirements in sections 4201 and 4211 of P.L. 100–203 that nursing facilities with more than 120 beds must have at least one social worker (with at least a bachelor's degree in social work or similar professional qualification) employed full-time to provide or assure the provision of social services. Facilities could meet this requirement by employing either a person with a dregree in social work or with similar professional qualifications, such as a degree in a related field and previous supervised experience in meeting individual psycho-social needs. It is the intent of the conferees that the Secretary ensure that requirements regarding consultation and supervision of social work services be at least as stringent as those in effect prior to enactment of these changes.

The conferees also wish to clarify that it was the intent of sections 4201 and 4211 of P.L. 100–203 that the Secretary ensure that the requirements for dietary services be at least as stringent as those in effect prior to enactment of P.L. 100–203.

36. Technical Amendment Relating to Home and Community-Based Services (Section 19 of Senate amendment)

Present law

Comparable provision included in section 4418(a) of Public Law 100–203.

37. Technical Amendments Relating to New Jersey Respite Care Pilot Project (Section 20 of Senate amendment)

Present law

Comparable provision included in section 4418(o) of Public Law 100–203.

38. Treatment of Garden State Health Plan (Section 25 of Senate amendment)

Present law

Comparable provision included in section 4113 of Public Law 100–203.

39. Technical Amendments Relating to the Omnibus Budget Reconciliation Act of 1987

Conference agreement

PART A AND AMENDMENTS AFFECTING BOTH PARTS A AND B

The conference agreement includes a number of technical and conforming amendments to the Medicare Part A and Parts A and B provisions of OBRA-87. These include:

(1) The prohibition on the issuance by the Secretary of any regulation, instruction, or other policy which is estimated by the Secretary to result in a net reduction in expenditures of more than $50 million is extended to October 15, 1989;

(2) Clarification that the regional floor on hospital payment applies on a census region basis, not a wage area basis;

(3) Clarification that outlying counties of metropolitan areas can only be designated as urban if they meet the commuting rules and all other applicable standards for designation as part of an urban area;

(4) In the case of hospitals with more than 49 beds using swing beds, authorization is provided to continue payment for patients in the hospital receiving skilled mursing care when the hospital reaches its limit for swing bed care;

(5) Clarification that the hospital cost report is to be permanent;

(6) Revisions to the uniform hospital reporting demonstration program to (i) delete date elements on which it is not feasible to collect information at this time; (ii) allow additional time for the collection of data and the preparation of a report; and, (iii) extend the period of time during which funds may be expended for the demonstration;

(7) Amendments to conform anti-fraud and abuse provisions of OBRA '87 to existing statutory provisions;

(8) Extension of the date for submission of a report on hospital quality assurance required by OBRA '86 to January 1, 1990.

(9) Clarification that the rule regarding payment for hospital services by pre-paid plans under section 1876 applies to contracts established under pre-TEFRA demonstration authorities;

(10) Clarification that the hospital payment rule applies only in the case of a pre-paid which does not have a contract with the hospital or the skilled nursing facility seeking payment for its services. Most often, the rule would apply in the case of out-of-plan services or when contract negotiations have not been successful. The hospital or the skilled nursing facility are free to establish any level or type of payment they wish through negotiations pursuant to a contract;

(11) Clarification of the application of the 50/50 rule to H.I.P./Network.

PART B AND PROS

The conference agreement includes a number of technical and conforming amendments to the Medicare Part B and PRO provisions of OBRA-87. These include:

(1) Consolidation of definitions relating to physician payment in new Section 1842(i);

(2) Amendments clarifying that there is only one prevailing charge for payment of physicians' services calculated on the basis of customary charges of participating and non-participating physicians. The differential between participating and non-participating physicians continues without change;

(3) Clarifying that reductions in payment for cataract surgery and requirements relating to the use of an assistant at-surgery for cataract surgery also apply to insertion of an interocular lens subsequent to cataract removal;

(4) Conforming amendments regarding maximum allowable actual charge limits for reductions in payment for concurrent anesthesia services;

(5) Clarifying amendment to the purchase service provision, including an amendment to allow for billing for such services on an unassigned basis;

(6) Amendments clarifying that the scholarship loan default offset provision applies to non-physician defaulters and to physician and non-physician defaulters under the Health Education Assistance Loan program and the Physician Shortage Area Scholarship program;

(7) An amendment clarifying that the 1975 prevailing charge floor continues but is phased-out as it is no longer needed;

(8) Corrections and clarifying amendments to the durable medical equipment fee schedule;

(9) Clarifying penalties for improper billing of interocular lenses included in payment to ASCs;

(10) Consolidating amendments incorporating OBRA-87 policies regarding clinical labs into the Social Security Act and clarifying amendments related to the effective date for the elimination of the 2% differential for hospital laboratories;

(11) Clarifying amendments for new Section 1846;

(12) Clarification of provisions relating to payment of hospital outpatient departments for radiology services;

(13) Clarifying amendments that the standard coinsurance applies to services of nurse midwives and clinical psychologists and conforming amendments applying the same penalties for improper unassigned billings to these services as apply to the services of certified registered nurse anesthetists and physician assistants;

(14) Clarifying amendments to the provision requiring coordination of claims with Medigap insurers and an amendment delaying the effectiveness of this provision for Medigap policies sold in states which did not enact necessary changes prior to July 1, 1988.

NURSING HOME REFORM

The conference agreement includes a number of technical and correcting amendments to the Medicare and Medicaid Nursing Home Reform provisions of OBRA 87. These include amendments revising effective date and other requirements. The effective dates for certain Medicare requirements are changed from the first date noted to the second date noted as follows:

(1) requirement that skilled nursing facilities conduct resident assessments: from October 1, 1990 to January 1, 1991;

(2) required training of nurse aides used by facilities: from October 1, 1989 (or January 1, 1990, in the case of an individual used as a nurse aid before July 1, 1989) to January 1, 1990;

(3) requirement for States to specify approved nurse aide training and competency evaluation programs: from March 1, 1989 to January 1, 1989;

(4) requirement for States to review and reapprove nurse aide training and competency evaluation: from March 1, 1990 to January 1, 1990;

(5) requirement for States to establish nurse aide registries: from March 1, 1989 to January 1, 1989;

(6) requirement for States to provide for an appeals process for transfers: from October 1, 1990 to October 1, 1989;

(7) requirement for States to specify the resident assessment instrument: from July 1, 1989 to July 1, 1990;

(8) requirement for the Secretary to establish guidelines for States appeals process for transfers: from October 1, 1989 to October 1, 1988;

(9) requirement for the Secretary to specify a minimum data set of core elements and common definitions for resident assessments: from July 1, 1989 to January 1, 1989;

(10) requirement for the Secretary to designate one or more resident assessment instruments: from October 1, 1990 to April 1, 1990;

(11) requirement that a facility permit immediate access to any resident by any representative of the Secretary or State, by an ombudsman, or by the resident's individual physician: effective on the date of enactment;

(12) requirement for the Secretary to develop, test, and validate standard and extended survey protocols: from October 1, 1990 to January 1, 1990.

Certain Medicaid effective dates have also been revised:

(1) requirement for States to specify approved nurse aide training and competency evaluation programs: from September 1, 1988 to January 1, 1989;

(2) requirement for States to review and reapprove nurse aide training programs: from September 1, 1990 to January 1, 1990;

(3) agreement between State and Secretary for disposition of residents who require active treatment: from October 1, 1988 to April 1, 1989;

(4) requirement for the Secretary to establish requirements for the approval of nurse aide training and competency evaluation programs: from July 1, 1988 to September 1, 1988;

(5) requirement that a facility permit immediate access to any resident by any representative of the Secretary or State, by an ombudsman, or by the resident's individual physician: effective on the date of enactment.

These amendments also clarify that nursing facilities are required to manage the personal funds of residents if requested to do so by the resident. The amendments also require States to make available to the public information in nurse aide registries.

With regard to requirements for social workers included in the OBRA 87 amendments, the conferees intend that the Secretary ensure that requirements regarding consultation and supervision of social work services be at least as stringent as those in effect prior to enactment of the OBRA changes.

RURAL HEALTH

Clarifies that the set aside for demonstrations applies to both research and demonstrations but only to funds appropriated to and expended by the Health Care Financing Administration. Conforms statutory language to intent of conferees that there be equal ten percent set-asides for rural and for inner city research and demonstrations.

From the Committee on Ways and Means, for consideration of titles I, II, and IV of the House bill, and the entire Senate amendment (except for secs. 14, 14A, 14B, 14C, 19, 20, and 25), and modifications committed to conference:

DAN ROSTENKOWSKI,
PETE STARK,
BRIAN J. DONNELLY,
WILLIS D. GRADISON, Jr.

From the Committee on Energy and Commerce, for consideration of titles II, III, and IV of the House bill, and the Senate amendment (except for secs. 2, 3, 12, and 18(a)) and for sec. 6 of the Senate amendment insofar as consideration of such section entails changes in eligibility requirements to participate in part B of the Medicare program, and modifications committed to conference:

JOHN D. DINGELL,
HENRY A. WAXMAN,
RON WYDEN,
EDWARD R. MADIGAN
(except for sec. 204 of the House bill and sec. 7 of the Senate amendment),

For consideration of sec. 204 of the House bill and sec. 7 of the Senate amendment:

MICHAEL BILIRAKIS,

From the Committee on Education and Labor, for consideration of sec. 21 of the Senate amendment, and modifications committed to conference:

GUS HAWKINS,
WILLIAM CLAY,
JAMES JEFFORDS,
Managers on the part of the House.

LLOYD BENTSEN,
MAX BAUCUS,
BILL BRADLEY,
GEORGE MITCHELL,
DAVID PRYOR,
JOHN H. CHAFEE,
JOHN HEINZ,
DAVID DURENBERGER,
Managers on the part of the Senate.

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